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106TH CONGRESS
2D SESSION

S. 2342

To amend the Medicare program under title XVIII of the Social Security Act to make Medicare more competitive and efficient, to provide for a prescription drug benefit, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 4, 2000

Mr. MOYNIHAN (by request) introduced the following bill; which was read twice and referred to the Committee on finance

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A BILL

To amend the Medicare program under title XVIII of the Social Security Act to make Medicare more competitive and efficient, to provide for a prescription drug benefit, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Modernization Act of 2000''.

(b) REFERENCES.—Except where otherwise specifically provided, references in this Act shall be considered

to be made to the Social Security Act, or to a section or other provision thereof.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT

PART A—COMPETITIVE DEFINED BENEFIT

SEC. 101. COMPETITIVE DEFINED BENEFIT.

(a) PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS BASED ON RISK-ADJUSTED BIDS.—

(1) IN GENERAL.—Section 1853(a)(1) (42 U.S.C. 1395w–23(a)(1)) is amended by striking ''the Secretary shall make'' and all that follows and inserting ''the Secretary shall make, to each Medicare+Choice organization, with respect to coverage of an individual for a month under this part in a Medicare+Choice payment area, separate monthly payments with respect to benefits under parts A and B combined, and (as applicable) with respect to benefits under part D, as determined in accordance with this section.''.

(2) ANNUAL DETERMINATION AND ANNOUNCEMENT OF PAYMENT FACTORS.—

(A) IN GENERAL.—Section 1853(b) (42 U.S.C. 1395w–23(b)) is amended—

(i) in paragraph (1), by striking ''the calendar year concerned'' and all that follows and inserting ''the calendar year concerned, the following factors, as defined in paragraph (4):

''(A) national monthly per capita costs,

''(B) the benchmark amount for each payment area, and

''(C) the health status and demographic adjustment factors to be used in making payment for individual enrollees.'';

(ii) in paragraph (3), by striking ''monthly adjusted'' and all that follows and inserting ''such estimates, factors, and amounts''; and

(iii) by adding at the end the following new paragraphs:

''(4) FACTORS USED IN ADJUSTING BIDS FOR MEDICARE+CHOICE ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—

''(A) IN GENERAL.—Subject to paragraph (5), the Secretary shall use, for purposes of adjusting plan bids and determining enrollee pre-

miums under this part, the factors specified in this paragraph, which factors—

"(i) shall be calculated separately for benefits under parts A and B combined, and under part D; and

"(ii) shall be calculated separately for—

"(I) beneficiaries who are aged or disabled; and

"(II) beneficiaries who have end stage renal disease until such time as the Secretary establishes an integrated risk adjustment system for the groups specified in subclauses (I) and (II).

"(B) NATIONAL MONTHLY PER CAPITA COSTS.—

"(i) IN GENERAL.—The term 'national monthly per capita costs' means (subject to clause (ii)) the projected national, monthly, per capita costs of benefits under this title and associated claims processing costs for individuals entitled to benefits under part A and individuals enrolled

in the program under part B who are not enrolled in a plan under this part.

"(ii) EXCLUSION OF DSH AND GME COSTS.—The calculation of costs under clause (i) shall not take into account any amounts attributable to—

"(I) payment adjustments under section 1886(d)(5)(F) for hospitals serving a significantly disproportionate number of low income patients;

"(II) payments for costs of graduate medical education under section 1886(h); or

"(III) payments for indirect costs of medical education under section 1886(d)(5)(B).

"(C) BENCHMARK AMOUNT.—

"(i) The term 'benchmark amount' means, for a payment area, an amount equal to the greater of—

"(I) except as provided in clause (ii), 1/12 of the annual Medicare+Choice capitation rate that would have applied in that payment

area under section 1853(c) (as in effect prior to the enactment of the Medicare Modernization Act of 2000); or

"(II) the product of 96 percent of national monthly per capita costs and the ratio, for a previous period, of—

"(aa) monthly per capita costs of Medicare benefits for individuals entitled to benefits under part A and individuals enrolled in the program under part B in that payment area (adjusted for relative risk due to health status and demographic adjustment factors) to—

"(bb) the weighted average for all payment areas of such monthly per capita costs.

"(ii) If the amount calculated under clause (i)(I) for a year for all payment areas is equal to either the minimum amount or the blended capitation rate, for all subsequent years the Secretary shall

not calculate the rates described in that clause and the amount under such clause instead shall be equal to the product of 96 percent of national monthly per capita costs and the ratio of—

"(I) the annual Medicare+Choice capitation rate for the last year that such rates were calculated under such clause to—

"(II) the weighted average of the area-specific Medicare+Choice capitation rates for that same year.

"(iii) For years prior to 2005, with regard to benefits under part D, the Secretary may use 96 percent of national monthly per capita costs as the benchmark amount for all payment areas or provide for regional rather than payment area-specific determinations of the benchmark amounts.

"(D) HEALTH STATUS AND DEMOGRAPHIC ADJUSTMENT FACTORS.—The term 'health status and demographic adjustment factors' means health status and such other risk factors as age, disability status, gender, institutional sta-

tus, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence, and in that event will make comparable adjustments to the benchmark amounts. For years prior to 2005, with regard to part D benefits, the Secretary shall not be required to include health status in the factors described in this subparagraph.''.

(B) CONFORMING AMENDMENT.—Section 1853(c)(7) is relocated and redesignated as section 1853(b)(5), indented accordingly, and amended by striking all that follows ''shall adjust appropriately'' and inserting ''national monthly per capita costs for the following year''.

(3) SUBMISSION OF BIDS BY MEDICARE+CHOICE ORGANIZATIONS.—

(A) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23) is amended by striking subsection (c) and inserting the following new subsection:

''(c) SUBMISSION OF BIDS BY MEDICARE+CHOICE ORGANIZATIONS.—

''(1) IN GENERAL.—Each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan which it intends to offer in a service area in the following year—

''(A) by April 1, notice of such intent and information on the service area and plan type for each plan; and

''(B) by July 1—

''(i) the information described in paragraph (2) for the type of plan involved; and

''(ii) the enrollment capacity (if any) in relation to the plan and area.

''(2) INFORMATION REQUIRED FOR COMPETITIVE PLANS.—The information described in this paragraph, which shall be submitted separately for combined part A and part B benefits, and for part D benefits, is as follows:

''(A) The monthly plan bid for the provision of benefits.

''(B) The actuarial value of the reduction in cost-sharing for Medicare benefits included

in each plan bid (which value shall not exceed 15 percent of the value of the balance of the bid).

''(C) A description of the cost-sharing for Medicare benefits that will apply and the actuarial value of such cost-sharing.

''(D) For each supplemental benefits package offered (if any), the adjusted community rate of the package, the monthly supplemental premium, a description of cost-sharing and such other information as the Secretary considers necessary.

''(E) The assumptions used with respect to numbers, in each payment area, of—

''(i) enrolled individuals who are aged or disabled; and

''(ii) enrolled individuals who have end-stage renal disease.''.

(B) CONFORMING AMENDMENTS.—

(i) Paragraphs (3) and (5) of section 1854(a) are relocated and redesignated as paragraphs (3) and (4), respectively, of section 1853(c), as amended.

(ii) Section 1853(c)(3)(B) (42 U.S.C. 1395w–23(c)(3)(B)), as redesignated, is amended by striking ''beneficiary''.

(iii) Section 1853(c)(4)(B) (42 U.S.C. 1395w–23(c)(3)(B)), as redesignated, is amended by striking ''or subparagraphs (A)(ii) and (B) of paragraph (4)''.

(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT.—Section 1853 is further amended—

(A) by redesignating subsections (d) through (h) as subsections (e) through (i), respectively; and

(B) by adding after subsection (c) the following new subsection:

''(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT.—

''(1) CONVERSION TO NORMALIZED BIDS.—

''(A) NORMALIZED BIDS.—Subject to subparagraph (B), the Secretary shall adjust each monthly plan bid submitted under subsection (c) for the relative risk of enrollees in such plan based on health status and demographic adjustment factors.

''(B) SPECIAL RULE FOR PLAN BIDS FOR PART D BENEFITS BEFORE 2005.—The Secretary is not required, for years before 2005, to make the adjustments described in subparagraph (A) with respect to plans for part D benefits.

''(2) COMPARISON TO PLAN BENCHMARK AMOUNT.—

''(A) DETERMINATION OF PLAN BENCHMARK.—The Secretary shall determine, using the plan enrollment assumptions included in the organization's bid, a plan benchmark amount for each plan equal to—

''(i) (until such time as the Secretary establishes an integrated risk adjustment system for individuals who are aged or disabled and for individuals who have end-stage renal disease)—

''(I) the product of the weighted average of the benchmark amounts for the payment areas included in the plan's service area for individuals who are aged or disabled and the number of such individuals in the plan, plus

''(II) the product of the weighted average of the benchmark amounts for the payment areas included in the plan's service area for individuals who have end-stage renal disease and the number of such individuals in the plan,divided by the total number of individuals in subclauses (I) and (II); and

''(ii) (after such time) the weighted average of the benchmark amounts for the payment areas included in the plan's service area.

''(B) COMPARISON TO BENCHMARK; DETERMINATION OF PAYMENT AMOUNT.—The monthly payment to a Medicare+Choice organization with respect to each individual enrolled in a plan shall be set as follows:

''(i) IF BID DOES NOT EXCEED BENCHMARK.—If the normalized bid determined under paragraph (1) does not exceed the plan benchmark amount determined under subparagraph (A), the monthly payment shall be the normalized bid, adjusted to account for the health status and

demographic adjustment factors of the individual enrollee.

"(ii) IF BID EXCEEDS BENCHMARK.—If the normalized bid determined under paragraph (1) exceeds the plan benchmark amount determined under subparagraph (B), the monthly payment shall be the normalized bid, adjusted as described in clause (i), minus the monthly excess premium determined under section 1854.".

(b) PREMIUMS.—

(1) DETERMINATION OF PREMIUM AMOUNT.—Section 1854 (42 U.S.C. 1395–4) is amended—

(A) by striking subsection (a) and redesignating subsections (b) and (c) as subsections (a) and (b);

(B) by adding after subsection (b) the following new subsection:

"(c) DETERMINATION OF MEDICARE PREMIUM REDUCTION AND EXCESS PREMIUM.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall subtract the normalized bid (determined under section 1853(d)(1)) from the plan's benchmark amount (determined under section 1853(d)(2)) to determine the Medicare premium re-

duction or monthly excess premium for plan enrollees.

''(2) ADJUSTMENT.—If the difference between the normalized bid and the plan's benchmark amount—

''(A) is a positive amount, 75 percent of that amount shall be equal to—

''(i) the monthly Medicare premium reduction for individuals enrolled in the plan (up to the entire amount of the premium for part B or part D, as applicable); and

''(ii) the remainder, if any, under clause (i) shall be equal to the additional reduction in the actuarial value of plan cost-sharing for plan enrollees;

''(B) is a negative amount, the absolute value of that amount shall equal the monthly excess premium for individuals enrolled in the plan.

(2) LIMITATION ON ENROLLEE LIABILITY.—

(A) FOR BASIC BENEFITS.—Section 1854(e)(1) (42 U.S.C. 1395w-4(e)(1)) is amended to read as follows:

''(1) FOR BASIC BENEFITS.—The sum of—

"(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1851(a)(2)(A) or (C) of an organization with respect to benefits described in section 1852(a)(1);

"(B) the reduction in cost sharing included in the plan bid;

"(C) the portion, if any, of the monthly supplemental premium that is in lieu of plan cost-sharing for Medicare benefits; and

"(D) any additional reduction in cost-sharing under subsection (c)(2)(A) (determined separately with respect to benefits under parts A and B, and benefits under part D) must equal the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to such benefits if they were not members of a Medicare+Choice organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).".

(B) FOR SUPPLEMENTAL BENEFITS.—Section1854(e)(2) (42 U.S.C. 1395w–4(e)(2)) is amended—

(i) by striking ''section 1851(a)(2)(A)'' and inserting ''subparagraph (A) or (C) of section 1851(a)(2)'';

(ii) by striking ''(multiplied by 12)''; and

(iii) by striking ''may not exceed'' and inserting ''must equal''.

(c) OTHER CHANGES IN PLAN DESIGN.—

(1) ALLOWING PLANS TO INCLUDE COST SHARING REDUCTION IN THEIR BASIC BENEFITS.—Section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)) is amended by striking subparagraph (B) and inserting the following—

''(B) at plan option, reduction in cost-sharing for part A and part B benefits, or part D benefits, that would otherwise be applicable (the actuarial value of such reduction however shall not exceed 15 percent of the value of the portion of the bid related to combined part A and part B benefits, or part D benefits, as applicable).''.

(2) ELIMINATION OF MANDATORY SUPPLEMENTAL BENEFITS.—Section 1852(a)(3) (42 U.S.C. 1395w–22(a)(3)) is amended by striking subparagraph (A) and redesignating subparagraphs (B) and (C) and subparagraphs (A) and (B).

(d) CONFORMING AMENDMENTS.—

(1) PREMIUM REDUCTIONS.—

(A) UNDER PART B.—

(i) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ''shall'' and all that follows and inserting ''shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), and (f), and thereafter further modified as required to comply with section 1854(c)(2)(A).''.

(ii) Section 1840 (42 U.S.C. 1395s) is amended by adding at the end the following:

''(i) The Secretary shall provide for necessary adjustments of the Medicare premium for Medicare+Choice enrollees determined under section 1854(c)(2)(A). This premium adjustment may be provided directly or as an adjustment to Social Se-

curity, Railroad Retirement and Civil Service Retirement benefits, as appropriate, as the Secretary determines feasible with the concurrence of such agencies.''.

(B) UNDER PART D.—

(i) Section 1859D(a)(2)(B) is amended by inserting ''thereafter further modified as required to comply with section 1854(c)(2)(A),'' before ''and rounded''.

(ii) Section 1859(b)(1) is amended by adding at the end the following:

''(C) The Secretary shall provide for necessary adjustments of the Medicare premium for Medicare+Choice enrollees determined under section 1854(c)(2)(A). This premium adjustment may be provided directly or as an adjustment to Social Security, Railroad Retirement and Civil Service Retirement benefits, as appropriate, as the Secretary determines feasible with the concurrence of such agencies.''.

(2) APPROPRIATIONS FOR GOVERNMENT CONTRIBUTION.—Section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) is amended by adding after subparagraph (B) the following new subparagraph:

''(C) an adjustment for the Government contribution to reflect the savings to the Trust Fund from enrollment in Medicare+Choice plans by beneficiaries who receive monthly Medicare premium reductions in accordance with section 1854(c)(2)(A).''.

(3) Section 1851(b)(1)(B) (42 U.S.C. 1395w–21(b)(1)(B)) is amended by striking ''section 1852(a)(1)(A)'' and inserting ''section 1852(a)(1)''.

(4) Section 1851(d)(2)(A) (42 U.S.C. 1395w–21(d)(2)(A)) is amended by striking ''At least 15 days before'' and inserting ''Before''.

(5) Part C is amended by striking ''BENEFICIARY'' each time it appears immediately before ''PREMIUM'' or ''PREMIUMS'', and by striking ''beneficiary'' each time it appears immediately before ''premium'' or ''premiums''.

(6) Section 1851(d)(4)(B) (42 U.S.C. 1395w–21(d)(4)(B)) is amended—

(A) by inserting ''(i)'' after ''PREMIUMS.—''; and

(B) by adding before the period ''; and (ii) the reduction in the part B and part D premiums, if any''.

(7) Section 1851(d)(4)(E) (42 U.S.C. 1395w–21(d)(4)(E)) is amended by striking ''includes mandatory supplemental benefits in its base benefit package or''.

(8) Section 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)) is amended by striking ''the annual Medicare+Choice capitation rate'' and inserting ''the national monthly per capita costs''.

(9) Section 1852(c)(1)(F) (42 U.S.C. 1395w–22(c)(1)(F)) is amended by striking clause (i) and redesignating clauses (ii) and (iii) as clauses (i) and (ii).

(10) Section 1853(a)(1)(B) (42 U.S.C. 1395w–23(a)(1)(B)) is amended by striking the first and second sentences.

(11) Section 1853(e)(3)(B) (42 U.S.C. 1395w–23(e)(3)(B)), as redesignated, is amended—

(A) in the caption, by striking ''BUDGET NEUTRALITY'';

(B) by striking ''adjust the payment rates'' and all that follows through ''that would have been made'' and inserting ''adjust the benchmark amounts otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the weighted av-

erage of the benchmark amounts under this section in the State equals the weighted average of benchmark amounts that would have been applicable''.

(12) Section 1853(i)(2) (42 U.S.C. 1395w–23(i)(2)), as redesignated, is amended—

(A) by inserting ''and'' at the end of subparagraph (A);

(B) by striking ''; and'' at the end of subparagraph (B) and inserting a period; and

(C) by striking subparagraph (C).

(13)(A) Section 1854(a)(2)(A) (42 U.S.C. 1395w–4(a)(2)(A)), as redesignated, is amended by striking ''the amount authorized to be charged'' and all that follows and inserting ''the amount required to be charged under subsection (c)(2)(B) for the plan.''.

(B) Section 1854(a)(2)(B) (42 U.S.C. 1395w–4(a)(2)(B)), as redesignated, is amended—

(i) by striking ''or Medicare+Choice fee-for-service plan'', and

(ii) by striking ''or (4)(B)''.

(14) Section 1854(e) (42 U.S.C. 1395w–4(e)) is amended by striking paragraph (4).

(15)(A) Paragraphs (3) and (4) of section 1854(f) (42 U.S.C. 1395w–4(f)) are relocated and redesignated as paragraphs (4) and (5) of subsection (e).

(B) Section 1854(e)(4) (42 U.S.C. 1395w–4(e)(4)), as so redesignated, is amended by striking ''subject to paragraph (4)'' and inserting ''subject to paragraph (5)''.

(C) Section 1854(f) (42 U.S.C. 1395w–4(f)) is stricken.

(16) Section 1858(c), as redesignated by section 201, is amended by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(e) EFFECTIVE DATE.—The amendments made by this section shall be effective for 2003 and succeeding years.

PART B—PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICARE

SEC. 111. CARE COORDINATION SERVICES.

(a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding after section 1866 the following new section:

''SEC. 1866A. CARE COORDINATION SERVICES.

''(a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2002, may implement a care coordination services program in accordance with the provisions of this section under which, in appropriate circumstances, eligible individuals may elect to have health care services covered under this title managed and coordinated by a designated care coordinator.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

''(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

''(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The Secretary shall specify criteria to be used in making a determination as to whether an individual may appropriately be enrolled in the care coordination services program under this section, which shall include at least a finding by the Secretary that for cohorts of individuals with characteristics identified by the Secretary, professional management and coordination of care can reasonably be expected to improve processes or outcomes of health care and to reduce aggregate costs to the programs under this title.

''(2) PROCEDURES TO FACILITATE ENROLLMENT.—The Secretary shall develop and implement procedures designed to facilitate enrollment of eligible individuals in the program under this section.

''(c) ENROLLMENT OF INDIVIDUALS.—

''(1) SECRETARY'S DETERMINATION OF ELIGIBILITY.—The Secretary shall determine the eligibility for services under this section of individuals who are enrolled in the program under this section and who make application for such services in such form and manner as the Secretary may prescribe.

''(2) ENROLLMENT PERIOD.—

''(A) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall be effective as of the first day of the month following the month in which the Secretary approves the individual's application under paragraph (1), shall remain in effect for one month (or such longer period as the Secretary may specify), and shall be automatically renewed for additional periods, unless terminated in accordance with such procedures as the Secretary shall establish by regulation.

''(B) LIMITATION ON REENROLLMENT.—The Secretary may establish limits on an individual's eligibility to reenroll in the program under this section if the individual has disenrolled from the program more than once during a specified time period.

''(d) PROGRAM.—The care coordination services program under this section shall include the following elements:

''(1) BASIC CARE COORDINATION SERVICES.—

''(A) IN GENERAL.—Subject to the cost-effectiveness criteria specified in subsection (b)(1), except as otherwise provided in this section, enrolled individuals shall receive services described in section 1905(t)(1) and may receive additional items and services as described in subparagraph (B).

''(B) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to individuals enrolled in the program under this section (subject to an assessment by the care coordinator of an individual's circumstance and need for such

benefits) in order to encourage enrollment in, or to improve the effectiveness of, such program.

''(2) CARE COORDINATION REQUIREMENT.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled in the program under this section may be entitled to payment under this title for any specified health care items or services only if the items or services have been furnished by the care coordinator, or coordinated through the care coordination services program. Under such provision, the Secretary shall prescribe exceptions for emergency medical services as described in section 1852(d)(3), and other exceptions determined by the Secretary for the delivery of timely and needed care.

''(3) REDUCTION OR ELIMINATION OF COST SHARING.—Notwithstanding any other provision of law, subject to the cost-effectiveness criteria specified in subsection (b)(1), the Secretary may provide for the reduction or elimination of beneficiary cost sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this title (other than the care coordination services and other benefits described in

paragraph (1)) and may limit such reduction or elimination to particular service areas.

''(e) CARE COORDINATORS.—

''(1) CONDITIONS OF PARTICIPATION.—In order to be qualified to furnish care coordination services under this section, an individual or entity shall—

''(A) be a health care professional or entity (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) meeting such conditions as the Secretary may specify;

''(B) have entered into a care coordination agreement; and

''(C) meet such criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physician's services).

''(2) AGREEMENT TERM; PAYMENT.—

''(A) DURATION AND RENEWAL.—A care coordination agreement under this subsection shall be for one year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in paragraph (1).

''(B) PAYMENT FOR SERVICES.—The Secretary may negotiate or otherwise establish payment terms and rates for services described in subsection (d)(1).

''(C) TERMS.—In addition to such other terms as the Secretary may require, an agreement under this section shall include the terms specified in subparagraphs (A) through (C) of section 1905(t)(3).''.

(b) COVERAGE OF CARE COORDINATION SERVICES AS A PART B MEDICAL SERVICE.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)) is amended—

(A) in the second sentence, by redesignating paragraphs (16) and (17) as clauses (i) and (ii); and

(B) in the first sentence—

(i) by striking ''and'' at the end of paragraph (14);

(ii) by striking the period at the end of paragraph (15) and inserting ''; and''; and

(iii) by adding after paragraph (15) the following new paragraph:

''(16) care coordination services furnished in accordance with section 1866A.''.

(2) PART B COINSURANCE AND DEDUCTIBLE NOT APPLICABLE TO CARE COORDINATION SERVICES.—

(A) COINSURANCE.—Section 1833(a)(1) is amended—

(i) by striking ''and'' at the end of subparagraph (R); and

(ii) by inserting before the final semicolon '', and (T) with respect to care coordination services described in section 1861(s)(16), the amounts paid shall be 100 percent of the payment amount established under section 1866C''.

(B) DEDUCTIBLE.—Section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(i) by striking ''and'' at the end of paragraph (5); and

(ii) by inserting before the final period '', and (7) such deductible shall not apply with respect to care coordination services (as described in section 1861(s)(16))''.

SEC. 112. DISEASE MANAGEMENT SERVICES.

(a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C. 1395 et seq.), as previously amended by this part, is further amended by adding after section 1866A the following new section:

"SEC. 1866B. DISEASE MANAGEMENT SERVICES.

''(a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2002, may implement a program in accordance with the provisions of this section under which certain eligible individuals may, in appropriate circumstances, receive disease management services from entities designated by the Secretary with respect to diagnoses that the Secretary determines are amenable to such management.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

''(b) INDIVIDUALS WHO MAY RECEIVE DISEASE MANAGEMENT SERVICES.—No individual shall be eligible for enrollment in a disease management program under this section unless the Secretary finds the following with respect to the individual:

''(1) DIAGNOSIS AND RELATED CHARACTERISTICS.—

"(A) IN GENERAL.—The individual has been diagnosed with congestive heart failure, chronic obstructive pulmonary disease, diabetes, or any other diagnosis, if the Secretary has determined with respect to such diagnoses that there is evidence that the provision of disease management services, over clinically relevant time-periods, to cohorts of individuals with such diagnoses can reasonably be expected to improve processes or outcomes of health care for the Medicare population and to reduce aggregate costs to the programs under this title.

"(B) ADDITIONAL FACTORS.—Where required by the Secretary, the individual also has certain clinical characteristics or conditions, exhibits certain patterns of utilization, or manifests other factors indicating the need for and potential effectiveness of disease management.

"(2) REFERRAL BY QUALIFIED INDIVIDUAL OR ENTITY.—The individual has been referred for consideration for such services by an individual or entity furnishing health care items or services, or by an entity administering benefits under this title.

"(c) PROCEDURES TO FACILITATE ENROLLMENT.—The Secretary shall develop and implement procedures de-

signed to facilitate enrollment of eligible individuals in the program under this section.

''(d) ENROLLMENT OF INDIVIDUALS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

''(1) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall remain in effect for one month (or such longer period as the Secretary may specify), and shall be automatically renewed for additional periods, unless terminated in accordance with such procedures as the Secretary shall establish by regulation.

''(2) LIMITATION ON REENROLLMENT.—The Secretary may establish limits on an individual's eligibility to reenroll in the program under this section if the individual has disenrolled from the program more than once during a specified time period.

''(e) DISEASE MANAGEMENT REQUIREMENT.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled in the program under this section may be entitled to payment under this title for any specified health care items or services only if the items or services have been furnished by the disease management organization, or coordinated through the disease management services program. Under such

provision, the Secretary shall prescribe exceptions for emergency medical services as described in section 1852(d)(3), and other exceptions determined by the Secretary for the delivery of timely and needed care.

''(f) DISEASE MANAGEMENT SERVICES.—

''(1) IN GENERAL.—Subject to the cost-effectiveness criteria specified in subsection (b)(1), disease management services provided to an individual under this section may include—

''(A) initial and periodic health screening and assessment;

''(B) management (including coordination with other providers) of, and referral for, medical and other health services related to the managed diagnosis (which may include referral for provision of such services by the disease management organization);

''(C) monitoring and control of medications (including coordination with the entity managing benefits for the individual under part D);

''(D) patient education and counseling;

''(E) nursing or other health professional home visits, as appropriate;

''(F) providing access for consultations by telephone with physicians or other appropriate

medical professionals, including 24-hour availability for emergency consultations;

"(G) managing and facilitating the transition to other care arrangements in preparation for termination of the disease management enrollment; and

"(H) such other services for which payment would not otherwise be made under this title as the Secretary shall determine to be appropriate.

"(2) VARIATIONS IN SERVICE PACKAGES.—The types and combinations of disease management services furnished under agreements under this section may vary (as permitted or required by the Secretary) according to the types of diagnoses, conditions, patient profiles being managed, expertise of the disease management organization, and other factors the Secretary finds appropriate.

"(3) REDUCTION OR ELIMINATION OF COST SHARING.—Notwithstanding any other provision of law, subject to the cost-effectiveness criteria specified in subsection (b)(1), the Secretary may provide for the reduction or elimination of beneficiary cost sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services

furnished under this title (other than those furnished under a service package developed under paragraph (2)), and may limit such reduction or elimination to particular service areas.

''(g) AGREEMENTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

''(1) ENTITIES ELIGIBLE.—Entities qualified to enter into agreements with the Secretary for the provision of disease management services under this section include entities that have demonstrated the ability to meet the performance standards and other criteria established by the Secretary with respect to—

''(A) the management of each diagnosis and condition with respect to which the entity, if designated, would furnish disease management services under this section; and

''(B) the implementation of each disease management approach that the entity, if designated, would implement under this section.

''(2) CONDITIONS OF PARTICIPATION.—In order to be eligible to provide disease management services under this section, an entity shall—

''(A) have in effect an agreement with the Secretary setting forth such obligations of the

entity as a disease management organization under this section as the Secretary shall prescribe;

''(B) meet the standards established by the Secretary under subsection (h); and

''(C) meet such other conditions as the Secretary may establish.

''(3) SECRETARY'S OPTION FOR NONCOMPETITIVE DESIGNATION.—The Secretary may designate an entity to provide disease management services under this section without regard to the requirements of section 5 of title 41, United States Code.

''(h) STANDARDS.—

''(1) QUALITY.—The Secretary shall establish standards for, and procedures for assessing, the quality of care provided by disease management organizations under this section, which shall include—

''(A) performance standards with respect to the processes or outcomes of health care or the health status of enrolled individuals, including procedures for establishing a baseline and measuring changes in health care processes or health outcomes with respect to managed diseases or health conditions;

''(B) a requirement that the organization meet such licensure and other accreditation standards as the Secretary may find appropriate; and

''(C) such other quality standards, including patient satisfaction, as the Secretary may find appropriate.

''(2) COST MANAGEMENT.—The Secretary shall establish a performance standard with respect to management or reduction of the aggregate costs of health care items and services related to managed health conditions furnished to enrolled individuals, including procedures for establishing a baseline and measuring changes in costs for such items and services.

''(i) PAYMENT.—

''(1) TERMS OF PAYMENT.—The Secretary may negotiate or otherwise establish payment terms and rates for service packages developed under subsection (f)(2).

''(2) WITHHOLDING OF PAYMENTS.—An agreement under subsection (g) may provide that the Secretary may withhold up to ten percent of the amount due a disease management organization under the basis of payment established under paragraph (1)

until such time as such organization meets a standard or standards specified in such agreement.

(b) COVERAGE OF DISEASE MANAGEMENT SERVICES AS A PART B MEDICAL SERVICE.—

(1) IN GENERAL.—Section 1861(s), as amended by section 111, is further amended—

(A) by striking ''and'' at the end of paragraph (15);

(B) by striking the period at the end of paragraph (16) and inserting ''and''; and

(C) by adding after paragraph (16) the following new paragraph:

''(17) disease management services furnished in accordance with section 1866B.''.

(2) PART B COINSURANCE AND DEDUCTIBLE NOT APPLICABLE TO DISEASE MANAGEMENT SERVICES.—

(A) COINSURANCE.—Section 1833(a)(1)(T) (42 U.S.C. 1395l(a)(1)(T)), as added by section 111(b)(2)(A), is amended to read as follows: ''(T) with respect to care coordination services described in section 1861(s)(16) and disease management services described in section 1861(s)(17), the amounts paid shall be 100 percent of the payment

amounts established under sections 1866A and 1866B, respectively;''.

(B) DEDUCTIBLE.—Section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 111(b)(2)(A), is further amended by inserting before the final period ''or to disease management services (as described in section 1861(s)(17))''.

SEC. 113. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

(a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C. 1395 et seq.), as previously amended by this part, is further amended by adding after section 1866B the following new section:

''SEC. 1866C. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

''(a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary shall implement a program to purchase, on behalf of individuals enrolled under this part certain competitively priced items and services for which payment may be made under part B.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may

administer the program under this section in accordance with section 1866M.

''(b) ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for agreement award purposes for the furnishing under part B of the items and services described in subsection (d) after 2002. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability and accessibility of individuals and entities able to furnish items and services, and the estimated savings to be realized by the use of competitive acquisition in the furnishing of items and services in the area.

''(c) AWARDING OF AGREEMENTS IN COMPETITIVE ACQUISITION AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (d) for each competitive acquisition area established

under subsection (b) for each class of items and services.

''(2) CONDITIONS FOR AWARDING AGREEMENT.—The Secretary may not enter an agreement with any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary, and that the aggregate amounts to be paid under the agreement are expected to be less than the aggregate amounts that would otherwise be paid.

''(3) TERMS OF AGREEMENT.—An agreement entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(d) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services described in paragraphs (3) and (5) through (9) of section 1861(s) (other than custom fabricated prostheses, as defined by the Secretary), and such other items or services as the Secretary may specify.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (20),

(2) by striking the period at the end of paragraph (21) and inserting ''; or'', and

(3) by adding after paragraph (21) the following:

''(22) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1866C(a)) by an entity other than an entity with which the Secretary has entered into an agreement under section 1866C(c) for the furnishing of such an item or service in that area, except in such cases of emergency or urgent need as the Secretary shall prescribe.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to items and services furnished after 2002.

SEC. 114. PROVIDER AND PHYSICIAN COLLABORATIONS.

Title XVIII (42 U.S.C. 1395 et seq.), as previously amended by this part, is further amended by adding after section 1866C the following new section:

''SEC. 1866D. PROVIDER AND PHYSICIAN COLLABORATIONS.

''(a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary may enter into agreements with specific providers, suppliers, or other individuals or entities for the furnishing of bundled items and services in selected sites of service or related to specific medical conditions or needs for an episode of care. The services may include any items or services covered under this title that the Secretary determines to be appropriate, including post-hospital services.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

''(b) BASIS OF SELECTION.—The Secretary shall select entities for agreements under this section on the basis of ability to provide services more efficiently, to provide improved coordination of care, to offer additional benefits, and to meet quality and other standards and beneficiary protections and other requirements set by the Secretary.

''(c) PAYMENT.—Payment under this section shall be made on the basis of all-inclusive rates. The all-inclusive rate paid to an entity for bundled items and services furnished during an episode of care under this section shall be less than the estimated amount of the payments that

the Secretary would have otherwise made for the items and services.

''(d) TERM OF AGREEMENT.—Agreements under this section shall be for periods that the Secretary may determine.

''(e) INCENTIVES TO BENEFICIARIES FOR USE OF CONTRACTING ENTITIES.—Notwithstanding any other provision of law, entities under a contract under this section may furnish additional services or waive part or all beneficiary cost sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this section.

''(f) BENEFICIARY ELECTION.—An individual entitled to benefits under this title who elects to obtain services under an agreement under this section shall agree to receive under such agreement all benefits related to the episode of care covered by the agreement (subject to such exceptions for emergency services and as the Secretary otherwise may specify).''.

SEC. 115. PREFERRED PARTICIPANTS.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as previously amended by this part, is further amended by adding after section 1866D the following new section:

"SEC. 1866E. PREFERRED PARTICIPANTS.

''(a) PROGRAM AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall implement beginning in 2002, a preferred participant program, under which the Secretary enters into agreements for the furnishing of health care items and services by individuals and entities participating in the program under part A or B of this title that provide high-quality, efficient health care.

''(2) LIMITATION.—The Secretary shall not implement the program under this section with respect to a service area, or with respect to a category of individuals and entities furnishing items and services in such service area, unless the Secretary estimates that to do so will reduce the cost and improve the quality of the programs under this title.

''(3) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary shall administer the program under this section in accordance with section 1866M.

''(b) PREFERRED PARTICIPANT AGREEMENT.—

''(1) CRITERIA AND TERMS.—In order to be eligible to participate in the program under part A or B as a preferred participant, an individual or entity shall meet the following conditions:

"(A) PARTICIPATION CRITERIA.—The individual or entity shall meet the criteria established by the Secretary under section 1866M(b)(5) (relating to quality, cost-effectiveness, categories of participants in service area, and such other standards or criteria as the Secretary may establish).

"(B) PAYMENT RATE.—The individual or entity shall agree to accept payment, for covered health care items and services furnished during the term of the agreement, at the rates established under this section (which may include rates in effect under part A or B, discounted rates, or such other rates as the Secretary may find appropriate).

"(2) DURATION.—A preferred participant agreement under this section shall be for a calendar year (or, in the case of an agreement commencing after the first day of January (or such later date as the Secretary may specify), for the remainder of such calendar year), and shall be annually renewable, at the option of the participant, while the participant continues to meet all applicable conditions of participation.

''(c) OPTION TO REDUCE COST SHARING.—Notwithstanding any other provision of law, subject to the cost-effectiveness criteria specified in subsection (a)(2), the Secretary may—

''(1) provide for the reduction or elimination of beneficiary cost sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this section, and may limit such reduction or elimination to particular service areas; and

''(2) permit individuals or entities under an agreement under this section to waive part or all of such beneficiary cost sharing.''.

(b) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''(uu) PREFERRED PARTICIPANT.—The term 'preferred participant' means an individual or entity that furnishes health care items or services under part A or B and that has in effect an agreement under section 1866E(b).''.

SEC. 116. CENTERS OF EXCELLENCE.

Title XVIII (42 U.S.C. 1395 et seq.), as previously amended by this part, is further amended by adding after section 1866E the following new section:

"SEC. 1866F. CENTERS OF EXCELLENCE.

''(a) IN GENERAL.—

''(1) COMPETITION TO FURNISH BUNDLED ITEMS AND SERVICES.—The Secretary, beginning in 2002, shall use a competitive process to enter into agreements with specific hospitals or other entities for the furnishing of bundled groups of items and services related to certain surgical procedures, and of other bundled groups of items and services (unrelated to surgical procedures) specified by the Secretary furnished during an episode of care (as defined by the Secretary). Such items and services may include any items or services covered under this title that the Secretary determines to be appropriate.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

''(b) ELIGIBILITY CRITERIA.—In order to be eligible for an agreement under this section, an entity shall—

''(1) meet quality standards established by the Secretary;

''(2) implement an ongoing quality assurance program approved by the Secretary; and

''(3) meet such other requirements as the Secretary may establish.

''(c) PAYMENT.—

''(1) IN GENERAL.—The Secretary shall establish criteria for identifying the health care items and services furnished by a center with an agreement under this section during an episode of care that are to be bundled together and for which payment shall be made on the basis of an all-inclusive rate.

''(2) PAYMENT LIMITATION.—

''(A) LIMITATION ON AGGREGATE PAYMENTS TO ENTITIES.—The estimated amount of aggregate payments to all entities under this section for a year shall be less than the estimated amount of aggregate payments that the Secretary would otherwise have made for such year, adjusted for changes in the number of individuals receiving services.

''(B) LIMITATION ON PAYMENTS TO PARTICULAR ENTITIES.—In no case shall the all-inclusive rate paid to an entity for items and services furnished during an episode of care under this section exceed the estimated amount of the payments that the Secretary would otherwise have made for such items and services.

''(d) AGREEMENT PERIOD.—An agreement period shall be for up to three years (subject to renewal).

''(e) INCENTIVES FOR USE OF CENTERS.—Notwithstanding any other provision of law, the Secretary may permit entities under an agreement under this section to furnish additional services or to waive part or all beneficiary cost sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this section.

''(f) BENEFICIARY ELECTION.—Notwithstanding any other provision of this title, an individual who voluntarily elects to receive items and services under an arrangement described in subsection (a)(1) with respect to an episode of care shall not be entitled to payment under this title for any such item or service furnished with respect to such episode of care other than through such arrangement, subject to such exceptions as the Secretary may prescribe for emergency medical services as described in section 1852(d)(3) and other cases of urgent need.''.

SEC. 117. DEMONSTRATION OF BONUS PAYMENTS FOR HEALTH CARE GROUPS.

Title XVIII (42 U.S.C. 1395 et seq.), as previously amended by this part, is further amended by adding after section 1866F the following new section:

''SEC. 1866G. DEMONSTRATION OF BONUS PAYMENTS FOR HEALTH CARE GROUPS.

''(a) DEMONSTRATION PROGRAM AUTHORIZED.—

''(1) IN GENERAL.—The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this title that—

''(A) encourage coordination of the care furnished to individuals under the programs under parts A and B by institutional and other providers, practitioners, and suppliers of health care items and services;

''(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

''(C) reward physicians for improving health outcomes.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

''(3) DEFINITIONS.—For purposes of this section, terms have the following meanings:

''(A) PHYSICIAN.—Except as the Secretary may otherwise provide, the term 'physician' means any individual who furnishes services

which may be paid for as physicians' services under this title .

''(B) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians' services under this title. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

''(b) ELIGIBILITY CRITERIA.—

''(1) IN GENERAL.—The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

''(2) PAYMENT METHOD.—A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c))—

''(A) to be paid on a fee-for-service basis; and

''(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

''(3) DATA REPORTING.—A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary require, for purposes of monitoring and evaluation of the demonstration under this section.

''(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

''(1) IN GENERAL.—The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of applica-

tion of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

''(2) OTHER CRITERIA.—The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

''(3) NOTICE REQUIREMENTS.—In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

''(d) INCENTIVES.—

''(1) PERFORMANCE TARGET.—The Secretary shall establish for each health care group participating in a demonstration under this section—

''(A) a base expenditure amount, equal to the average total payments under parts A, B, and D for patients served by the health care

group on a fee-for-service basis in a base period determined by the Secretary; and

''(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

''(2) INCENTIVE BONUS.—The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the Medicare savings realized for such year relative to the performance target.

''(3) ADDITIONAL BONUS FOR PROCESS AND OUTCOME IMPROVEMENTS.—At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the Medicare program resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

''(4) LIMITATION.—The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this title (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

''(e) SELECTION OF DEMONSTRATION PROJECTS.—The Secretary shall implement up to ten demonstrations under this section, selected competitively on the basis of criteria determined by the Secretary.''.

SEC. 118. ADMINISTRATION OF CERTAIN PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding after section 1866F the following new section:

''SEC. 1866M. GENERAL PROVISIONS FOR ADMINISTRATION OF CERTAIN PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT PROGRAMS.

''(a) IN GENERAL.—Except as otherwise specifically provided, the provisions of this section apply to the programs under the following provisions of this title:

''(1) section 1866A (care coordination services);

''(2) section 1866B (disease management services);

''(3) section 1866C (competitive acquisition of items and services);

''(4) section 1866D (provider and physician collaborations); and

''(5) section 1866E (preferred participants);

''(6) section 1866F (centers of excellence);

''(7) section 1866G (demonstration of bonus payments for health care groups).

''(b) PROVISIONS GENERALLY APPLICABLE TO DESIGNATED PROGRAMS.—The following provisions apply to programs specified in subsection (a), except as otherwise specifically provided:

''(1) BENEFICIARY ELIGIBILITY.—Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under a program specified in subsection (a) if such individual—

''(A) is enrolled in under the program under part B;

''(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1876 (or a similar organization operating under a demonstration project authority), an organization with an

agreement under section 1833(a)(1)(A), or a PACE program under section 1894; and

"(C) in the case of the programs specified in paragraphs (1), (2), (4), (6), and (7) of subsection (a), is entitled to benefits under part A.

"(2) SECRETARY'S DISCRETION AS TO SCOPE OF PROGRAM.—The Secretary may limit the implementation of a program specified in subsection (a) to—

"(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

"(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

"(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

"(D) any combination of any of the limits described in subparagraphs (A) through (C).

''(3) VOLUNTARY RECEIPT OF ITEMS AND SERVICES.—Except as provided in the authority for the program specified in subsection (a)(3), items and services shall be furnished to an individual under the programs specified in subsection (a) only at the individual's election.

''(4) AGREEMENTS.—The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the programs specified in subsection (a).

''(5) PROGRAM STANDARDS AND CRITERIA.—The Secretary shall establish performance standards for the programs specified in subsection (a) including, as applicable, standards for quality of health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

''(6) ADMINISTRATIVE REVIEW OF ADVERSE DECISION.—

''(A) DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES UNDER PROGRAMS.—An individual or entity furnishing services under a program specified in subsection (a) shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the individual or entity to provide health care items or services under such program.

''(B) DECISIONS AFFECTING BENEFICIARIES UNDER CARE COORDINATION SERVICES OR DISEASE MANAGEMENT SERVICES PROGRAMS.—

''(i) DETERMINATION OF INELIGIBILITY.—An individual shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a determination that the individual does not meet the criteria for eligibility to participate in a program specified in paragraph (1) or (2) of subsection (a).

''(ii) DENIAL OF PAYMENT FOR ITEMS OR SERVICES.—A beneficiary shall be entitled to a reconsideration or appeal of a denial of payment under section 1866A(d)(2) or 1866B(e)(2) in accordance with the provisions of section 1852(g), as if such section applied to this clause. In applying such section 1852(g), any reference to a Medicare+Choice organization is construed to refer to the program administrator or, if the Secretary has not contracted with a program administrator, to the Secretary.

''(7) SECRETARY'S REVIEW OF MARKETING MATERIALS.—An agreement with an individual or entity furnishing services under a program specified in subsection (a) shall require the individual or entity to guarantee that it will not distribute materials marketing items or services under such program without the Secretary's prior review and approval;

''(8) PAYMENT IN FULL.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement under a program specified in subsection (a) shall agree to accept such

payment as payment in full, and such payment shall be in lieu of any payments to which the individual or entity would otherwise be entitled under this title.

''(B) COLLECTION OF DEDUCTIBLES AND COINSURANCE.—Such individual or entity may collect any applicable deductible or coinsurance amount from a beneficiary.

''(c) CONTRACTS FOR PROGRAM ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary may administer a program specified in subsection (a) through a contract with a program administrator in accordance with the provisions of this subsection.

''(2) SCOPE OF PROGRAM ADMINISTRATOR CONTRACTS.—A contract under this subsection may, at the Secretary's discretion, relate to administration of any or all of the programs specified in subsection (a). The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

''(3) ELIGIBLE CONTRACTORS.—The Secretary may contract for the administration of the program with—

''(A) an entity that, under a contract under section 1816 or 1842, determines the

amount of and makes payments for health care items and services furnished under this title; or

"(B) any other entity with substantial experience in managing the type of program concerned.

"(4) CONTRACT AWARD, DURATION, AND RENEWAL.—

"(A) IN GENERAL.—A contract under this subsection shall be for an initial term of up to three years, renewable for additional terms of up to three years.

"(B) NONCOMPETITIVE AWARD AND RENEWAL FOR ENTITIES ADMINISTERING PART A OR PART B PAYMENTS.—The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 5 of title 41, United States Code.

"(5) APPLICABILITY OF FEDERAL ACQUISITION REGULATION.—The Federal Acquisition Regulation shall apply to program administration contracts under this subsection.

"(6) PERFORMANCE STANDARDS.—The Secretary shall establish performance standards for the program administrator including, as applicable,

standards for the quality and cost-effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

''(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A program administrator shall perform any or all of the following functions, as specified by the Secretary:

''(A) AGREEMENTS WITH INDIVIDUALS OR ENTITIES FURNISHING HEALTH CARE ITEMS AND SERVICES.—Determine the qualifications of individuals or entities seeking to enter or renew agreements to provide services under a program specified in subsection (a), and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

''(B) ESTABLISHMENT OF PAYMENT RATES.—Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

"(C) PAYMENT OF CLAIMS OR FEES.—Administer payments for health care items or services furnished under any such program.

"(D) PAYMENT OF BONUSES.—Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection (d)(2)(A)(ii) to individuals and entities furnishing items or services for which payment may be made under any such program.

"(E) LIST OF PROGRAM PARTICIPANTS.—Maintain and regularly update a list of individuals or entities with agreements to provide health care items and services under any such program, and ensure that such list, in electronic and hard copy formats, is readily available, as applicable, to—

"(i) individuals residing in the service area who are entitled to benefits under part A or enrolled in the program under part B;

"(ii) the entities responsible under sections 1816 and 1842 for administering payments for health care items and services furnished; and

"(iii) individuals and entities providing health care items and services in the service area.

"(F) BENEFICIARY ENROLLMENT.—Determine eligibility of individuals to enroll under a program specified in subsection (a) and provide enrollment-related services (but only if the Secretary finds that the program administrator has no conflict of interest caused by a financial relationship with any individual or entity furnishing items or services for which payment may be made under any such program, or any other conflict of interest with respect to such function).

"(G) OVERSIGHT.—Monitor the compliance of individuals and entities with agreements under any such program with the conditions of participation.

"(H) ADMINISTRATIVE REVIEW.—Conduct reviews of adverse determinations specified in subparagraph (A) and in subsection (b)(6).

"(I) REVIEW OF MARKETING MATERIALS.—Conduct a review of marketing materials proposed by an individual or entity furnishing services under any such program.

''(J) ADDITIONAL FUNCTIONS.—Perform such other functions as the Secretary may specify.

''(8) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

''(9) INFORMATION SHARING.—Notwithstanding section 1106 and section 552a of title 5, United States Code, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

''(d) RULES APPLICABLE TO BOTH PROGRAM AGREEMENTS AND PROGRAM ADMINISTRATION CONTRACTS.—

''(1) RECORDS, REPORTS, AND AUDITS.—The Secretary is authorized to require individuals and entities with agreements to provide health care items or services under programs specified under subsection (a), and entities with program administration

contracts under subsection (c), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of such program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

''(2) BONUSES.—Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under a program specified in subsection (a) from the Health Insurance and Supplementary Medical Insurance Trust Funds in amounts that do not exceed 50 percent of the savings to such Trust Funds attributable to such programs (or in the case of the program specified in subsection (a)(7), in amounts authorized under such program), in accordance with the following:

''(A) PAYMENTS TO PROGRAM ADMINISTRATORS.—The Secretary may make bonus payments under each program specified in subsection (a) to program administrators.

''(B) PAYMENTS TO INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the programs specified in paragraphs (1), (2), (5), and (7) of subsection (a), or may authorize a program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

''(ii) LIMITATIONS.—The Secretary may limit bonus payments under clause (i) to particular service areas, types of individuals or entities furnishing items or services under a program, or kinds of items or services, and may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of care, or such other factors as the Secretary determines to be appropriate.

''(3) ANTIDISCRIMINATION LIMITATION.—

"(A) IN GENERAL.—The Secretary shall not enter into an agreement with an individual or entity to provide health care items or services under a program specified under subsection (a), or with an entity to administer such a program, unless such individual or entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under such program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

"(B) CONSTRUCTION.—Subparagraph (A) shall not be construed to prohibit such individual or entity from taking any action explicitly authorized by the provisions of section 1866A (care coordination services) or section 1866B (disease management services).

"(e) LIMITATIONS ON JUDICIAL REVIEW.—The following actions and determinations with respect to a program specified in subsection (a) shall not be subject to review by a judicial or administrative tribunal:

"(1) limiting the implementation of a program under subsection (b)(2);

''(2) establishment of program participation standards under subsection (b)(5); or the denial or termination of, or refusal to renew, an agreement with an individual or entity to provide health care items and services under the program;

''(3) determination of a beneficiary's eligibility under subsection (b)(6)(B);

''(4) establishment of program administration contract performance standards under subsection (c)(6); or the refusal to renew a program administration contract; or the noncompetitive award or renewal of a program administration contract under subsection (c)(4)(B);

''(5) the establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract;

''(6) a determination with respect to a program (where specifically authorized by the program authority or by subsection (d)(2))—

''(A) as to whether cost savings have been achieved, and the amount of savings;

''(B) as to whether, to whom, and in what amounts bonuses will be paid; or

''(C) as to whether to reduce or eliminate beneficiary cost-sharing.

''(f) APPLICATION LIMITED TO PARTS A AND B.—None of the provisions of this section or of the programs specified in subsection (a) shall apply to the programs under parts C and D.''.

(b) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by adding after paragraph (3) the following new paragraph:

''(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICARE.—In the case of a designated health service, if the designated health service is—

''(A) included in the services under section 1866A, 1866B, 1866D, or 1866F; and

''(B) is provided by an individual or entity meeting such criteria related to quality assurance, financial disclosure, and other factors as the Secretary may find appropriate.''.

SEC. 119. REPORTS TO CONGRESS ON PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT PROGRAMS.

Not later than two years after the date of enactment of the Medicare Modernization Act of 2000, and biennially thereafter for six years, the Secretary shall report to the Congress on the use of authorities enacted by sections 111 through 117 of this Act. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under title XVIII of the Social Security Act.

SEC. 120. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.

(a) CARRIERS TO INCLUDE ENTITIES THAT ARE NOT INSURANCE COMPANIES.—

(1) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is amended by striking ''with carriers'' and inserting ''with agencies and organizations (referred to as carriers)''.

(2) Section 1842(f) (42 U.S.C. 1395u(f)) is repealed.

(b) SECRETARIAL FLEXIBILITY IN CONTRACTING FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CARRIER FUNCTIONS.—

(1) Section 1816 (42 U.S.C. 1395h) is amended by striking everything after the heading but before subsection (b) and inserting the following:

''SEC. 1816. (a)(1) The Secretary may enter into contracts with agencies or organizations to perform any or all of the following functions, or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other organizations):

''(A) determine (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this part to be made to providers of services,

''(B) make payments described in subparagraph (A),

''(C) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as providers of services,

''(D) serve as a center for, and communicate to individuals entitled to benefits under this part and to providers of services, any information or instructions furnished to the agency or organization by the Secretary, and serve as a channel of communication

from individuals entitled to benefits under this part and from providers of services to the Secretary,

''(E) make such audits of the records of providers of services as may be necessary to insure that proper payments are made under this part,

''(F) perform the functions described by subsection (d), and

''(G) perform such other functions as are necessary to carry out the purposes of this part.

''(2) As used in this title and title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section.''.

(2) Subsections (d) and (e) of section 1816 (42 U.S.C. 1395h) are amended to read as follows:

''(d) Each provider of services shall have a fiscal intermediary that—

''(1) acts as a single point of contact for the provider of services under this part,

''(2) makes its services sufficiently available to meet the needs of the provider of services, and

''(3) is responsible and accountable for arranging the resolution of issues raised under this part by the provider of services.

''(e) The Secretary, in evaluating the performance of a fiscal intermediary, may solicit comments from providers of services.''.

(3)(A) Section 1816(b)(1)(A) (42 U.S.C. 1395h(b)(1)(A)) is amended by striking ''after applying the standards, criteria, and procedures'' and inserting ''after evaluating the ability of the agency or organization to fulfill the contract performance requirements''.

(B) Section 1816(f)(1) (42 U.S.C. 1395h(f)(1)) is amended to read as follows:

''(f)(1) The Secretary may consult with Medicare+Choice organizations under part C of this title, providers of services and other persons who furnish items or services for which payment may be made under this title, and organizations and agencies performing functions necessary to carry out the purposes of this part with respect to performance requirements for contracts under subsection (a).''.

(C) The second sentence of section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended to read as follows: ''The Secretary may consult with Medicare+Choice organizations under part C of this title, providers of services and other persons who furnish items or services for which pay-

ment may be made under this title, and organizations and agencies performing functions necessary to carry out the purposes of this part with respect to performance requirements for contracts under subsection (a).''.

(D) Section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended by striking the third sentence.

(E) The matter in section 1842(b)(2)(B) (42 U.S.C. 1395u(b)(2)(B)) preceding clause (i) is amended by striking ''establish standards'' and inserting ''develop contract performance requirements''.

(F) Section 1842(b)(2)(D) (42 U.S.C. 1395u(b)(2)(D)) is amended by striking ''standards and criteria'' each place it occurs and inserting ''contract performance requirements''.

(4)(A) The matter in section 1816(b) (42 U.S.C. 1395h(b)) preceding paragraph (1) is amended by striking ''an agreement'' and inserting ''a contract''.

(B) Paragraphs (1)(B) and (2)(A) of section 1816(b) (42 U.S.C. 1395h(b)) are each amended by striking ''agreement'' and inserting ''contract''.

(C) The first sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking ''An agreement'' and inserting ''A contract''.

(D) The last sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking ''an agreement'' and inserting ''a contract''.

(E) The matter in section 1816(c)(2)(A) (42 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is amended by striking ''agreement'' and inserting ''contract''.

(F) Section 1816(c)(3)(A) (42 U.S.C. 1395h(c)(3)(A)) is amended by striking ''agreement'' and inserting ''contract''.

(G) Section 1816(h) (42 U.S.C. 1395h(h)) is amended—

(i) by striking ''An agreement'' and inserting ''A contract'', and

(ii) by striking ''the agreement'' each place it occurs and inserting ''the contract''.

(H) Section 1816(i)(1) (42 U.S.C. 1395h(i)(1)) is amended by striking ''an agreement'' and inserting ''a contract''.

(I) Section 1816(j) (42 U.S.C. 1395h(j)) is amended by striking ''An agreement'' and inserting ''A contract''.

(J) Section 1816(k) (42 U.S.C. 1395h(k)) is amended by striking ''An agreement'' and inserting ''A contract''.

(K) Section 1816(l) (42 U.S.C. 1395h(l)) is amended by striking ''an agreement'' and inserting ''a contract''.

(L) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is amended by striking ''agreements'' and inserting ''contracts''.

(M) Section 1842(h)(3)(A) (42 U.S.C. 1395u(h)(3)(A)) is amended by striking ''an agreement'' and inserting ''a contract''.

(5)(A) The matter in section 1816(c)(2)(A) (42 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is amended by inserting ''that provides for making payments under this part'' after ''this section''.

(B) Section 1816(c)(3)(A) (42 U.S.C. 1395h(c)(3)(A)) is amended by inserting ''that provides for making payments under this part'' after ''this section''.

(C) Section 1816(k) (42 U.S.C. 1395h(k)) is amended by inserting ''(as appropriate)'' after ''submit''.

(D) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is amended by

striking ''some or all of the following functions'' and inserting ''any or all of the following functions, or parts of those functions''.

(E) The first sentence of section 1842(b)(2)(C) (42 U.S.C. 1395u(b)(2)(C)) is amended by inserting ''(as appropriate)'' after ''carriers''.

(F) The matter preceding subparagraph (A) in the first sentence of section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended by inserting ''(as appropriate)'' after ''contract''.

(G) The matter in section 1842(b)(7)(A) (42 U.S.C. 1395u(b)(7)(A)) preceding clause (i) is amended by striking ''the carrier'' and inserting ''a carrier''.

(H) The matter in section 1842(b)(11)(A) (42 U.S.C. 1395u(b)(11)(A)) preceding clause (i) is amended by inserting ''(as appropriate)'' after ''each carrier''.

(I) The first sentence of section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting ''(as appropriate)'' after ''shall''.

(J) Section 1842(h)(5)(A) (42 U.S.C. 1395u(h)(5)(A)) is amended by inserting ''(as appropriate)'' after ''carriers''.

(6)(A) Section 1816(c)(2)(C) (42 U.S.C. 1395h(c)(2)(C)) is amended by striking ''hospital, rural primary care hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency'' and inserting ''provider of services''.

(B) The matter in section 1816(j) (42 U.S.C. 1395h(j)) preceding paragraph (1) is amended by striking ''for home health services, extended care services, or post-hospital extended care services''.

(7) Section 1842(a)(3) (42 U.S.C. 1395u(a)(3)) is amended by inserting ''(to and from individuals enrolled under this part and to and from physicians and other entities that furnish items and services)'' after ''communication''.

(8) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1), as amended by subsection (b)(4)(L), is amended by striking ''carriers with which contracts'' and inserting ''single contracts under section 1816 and this section together, or separate contracts with eligible agencies and organizations with which contracts''.

(c) ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS.—

(1) The matter in section 1816(b) (42 U.S.C. 1395h(b)) preceding paragraph (1) is amended by striking ''or renew''.

(2) The last sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking ''or renewing''.

(3) Section 1816(g) (42 U.S.C. 1395h(g)) is repealed.

(4) The last sentence of section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended by striking ''or renewing''.

(5) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking paragraph (5).

(d) REPEAL OF FISCAL INTERMEDIARY REQUIREMENTS THAT ARE NOT COST-EFFECTIVE.—Section 1816(f)(2) (42 U.S.C. 1395h(f)(2)) is amended to read as follows:

''(2) The contract performance requirements described in paragraph (1) shall include, with respect to claims for services furnished under this part by any provider of services other than a hospital, whether such agency or organization is able to process 75 percent of reconsiderations within 60 days and 90 percent of reconsiderations within 90 days.''.

(e) REPEAL OF COST REIMBURSEMENT REQUIREMENTS.—

(1) The first sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended—

(A) by striking the comma after ''appropriate'' and inserting ''and'', and

(B) by striking everything after ''subsection (a)'' up to the period.

(2) Section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is further amended by striking the second and third sentences.

(3) The first sentence of section 1842(c)(1) (42 U.S.C. 1395h(c)(1)) is amended—

(A) by striking ''shall provide'' the first place it occurs and inserting ''may provide'', and

(B) by striking everything after ''this part'' up to the period.

(4) Section 1842(c)(1) (42 U.S.C. 1395h(c)(1)) is further amended by striking the remaining sentences.

(5) Section 2326(a) of the Deficit Reduction Act of 1984 (42 U.S.C. 1395h nt) is repealed.

(f) SECRETARIAL FLEXIBILITY WITH RESPECT TO RENEWING CONTRACTS AND TRANSFER OF FUNCTIONS.—

(1) Section 1816(c) (42 U.S.C. 1395h(c)) is amended by adding at the end the following:

''(4)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts under this section.

''(B)(i) The Secretary may renew a contract with a fiscal intermediary under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the fiscal intermediary has met or exceeded the performance requirements established in the current contract.

''(ii) Functions may be transferred among fiscal intermediaries without regard to any provision of law requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers.''.

(2) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking everything before paragraph (2) and inserting the following:

''(b)(1)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts under this section.

''(B)(i) The Secretary may renew a contract with a carrier under subsection (a) from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the carrier has met or exceeded the performance requirements established in the current contract.

''(ii) Functions may be transferred among carriers without regard to any provision of law requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers.''.

(g) WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS.—

(1) Contracts under section 1816(a) (42 U.S.C. 1395h(a)) or 1842(a) (42 U.S.C. 1395u(a)) whose periods begin before or during the one year period that begins on the first day of the fourth calendar month that begins after the date of enactment of this section may be entered into without regard to any provision of law requiring competition.

(2) The amendments made by subsection (f) apply to contracts whose periods begin after the end

of the one year period specified in paragraph (1) of this subsection.

(h) EFFECTIVE DATES.—

(1) The amendments made by subsection (c) apply to contracts whose periods end at, or after, the end of the third calendar month that begins after the date of enactment of this section.

(2) The amendments made by subsections (a), (b), (d), and (e) apply to contracts whose periods begin after the third calendar month that begins after the date of enactment of this section.

SEC. 121. SPECIAL PROVISIONS FOR FUNDING OF ACTIVITIES RELATED TO CERTAIN OVERPAYMENT RECOVERIES AND PROVIDER ENROLLMENT AND REVERIFICATION OF ELIGIBILITY.

(a) FUNDING AVAILABLE UNDER THE MEDICARE INTEGRITY PROGRAM (MIP) APPROPRIATION FOR PROVIDER ENROLLMENT ACTIVITIES PERFORMED BY FISCAL INTERMEDIARIES AND CARRIERS.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(1) in subparagraph (A), by inserting ''and the activities specified in subparagraph (C)'' after ''the Medicare Integrity Program under section 1893''; and

(2) by adding at the end the following new subparagraph:

"(C)(i) Of the amounts appropriated under subparagraph (A), the amounts specified in clause (iii) shall be available to the Secretary for payment of the costs of the activities described in clause (ii) which are performed by entities with contracts under section 1816 or 1842.

"(ii) For purposes of clause (i), the activities specified in this paragraph are—

"(I) determinations as to whether overpayments were made to an individual or entity furnishing items or services for which payment may be made under this title and recovery of any such overpayments; and

"(II) activities related to enrolling such individuals and entities under the program under this title, including establishing billing privileges and records systems, processing applications, background investigations, and related activities.

"(iii) For purposes of clause (i), the amount specified under this clause is the lesser

of the amounts necessary to perform the activities described in clause (ii) or—

"(I) for fiscal year 2001, $14,000,000; and

"(II) for fiscal years 2002 and 2003, the amount for the preceding year, increased by 30 percent of the difference between the maximum amount specified in subparagraph (B) for such year and the maximum amount so specified for the preceding year.

"(iv) Amounts available under this subparagraph for the activities described in clause (ii) shall be in addition to any amounts that may otherwise be available to carry out such activities.".

(b) ADDITIONAL FUNCTIONS TO BE PERFORMED BY MIP CONTRACTORS.—

(1) REVERIFICATION OF ELIGIBILITY FUNCTION.—Section 1893(b) (42 U.S.C. 1395ddd(b)) is amended by adding at the end the following new paragraph:

"(6) activities related to reverifying the eligibility of individuals and entities described in para-

graph (1) to participate under the program under this title, and related activities.

(2) PROVIDER ENROLLMENT AND OVERPAYMENT RECOVERY FUNCTIONS ADDED AS MIP CONTRACTOR FUNCTIONS AFTER PHASE-IN PERIOD.—Section 1893(b) (42 U.S.C. 1395ddd(b)) is amended by adding at the end the following new paragraphs:

''(7) Activities related to enrolling individuals and entities described in paragraph (1) under the program under this title, including establishing billing privileges and records systems, processing applications, background investigations, and related activities.

''(8) Determinations with respect to overpayments made under this title that are discovered pursuant to the performance of an activity described in paragraph (1) or (2), and recovery of any such overpayments.''.

(3) EFFECTIVE DATES.—The amendment made by paragraph (1) shall be effective on and after October 1, 2000. The amendment made by paragraph (2) shall be effective on and after October 1, 2003.

TITLE II—MODERNIZING MEDICARE BENEFITS

PART A—PRESCRIPTION DRUG BENEFIT

SEC. 201. PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating section 1859 and part D as section 1858 and part F, respectively; and

(2) by adding after section 1858, as so redesignated, the following new part:

"PART D—PRESCRIPTION DRUG BENEFIT FOR THE AGED AND DISABLED

"SEC. 1859. ESTABLISHMENT OF PRESCRIPTION DRUG BENEFIT PROGRAM FOR THE AGED AND DISABLED.

''There is hereby established a voluntary insurance program to provide prescription drug benefits in accordance with the provisions of this part for individuals who are aged or disabled or have end stage renal disease and who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

"SEC. 1859A. SCOPE OF BENEFITS.

''(a) IN GENERAL.—The benefits provided to an individual enrolled in the insurance program under this part shall consist of—

''(1) payments made, in accordance with the provisions of this part, for covered prescription drugs (as specified in subsection (b)) dispensed by any pharmacy participating in the program under this part (and, in circumstances designated by the benefit manager, by a non-participating pharmacy), including any specifically named drug prescribed for the individual by a qualified health care professional regardless of whether the drug is included in a formulary established by the benefit manager if such drug is certified as medically necessary by such health care professional, up to the benefit limits specified in section 1859B; and

''(2) charging by participating pharmacies of—

''(A) the negotiated price for all covered prescription drugs, without regard to such benefit limit; and

''(B) the negotiated price (if any) established with respect to any drugs or classes of drugs described in subparagraphs (A) through (D) or (F) of section 1927(d)(2) that are avail-

able to individuals receiving benefits under this title.

''(b) COVERED PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Covered prescription drugs, for purposes of this part, include all prescription drugs (as defined in section 1859J(1)), including smoking cessation agents, except as otherwise provided in this subsection.

''(2) EXCLUSIONS FROM COVERAGE.—Covered prescription drugs shall not include drugs or classes of drugs described in subparagraphs (A) through (D) and (F) through (H) of section 1927(d)(2) (except to the extent otherwise specifically provided by the Secretary with respect to a drug in any of such classes).

''(3) EXCLUSION OF PRESCRIPTION DRUGS TO THE EXTENT COVERED UNDER PART A OR B.—A drug prescribed for an individual that would otherwise be a covered prescription drug under this part shall not be so considered to the extent that payment for such drug is available under part A or B (but shall be so considered to the extent that such payment is not available because benefits under part A or B have been exhausted).

"SEC. 1859B. PAYMENT OF BENEFITS; BENEFIT LIMITS.

''(a) PAYMENTS.—There shall be paid from the Prescription Drug Insurance Account within the Supplementary Medical Insurance Trust Fund (hereafter in this part referred to as the 'Prescription Drug Insurance Account' or 'the Insurance Account'), in the case of each individual who is enrolled in the insurance program under this part and who purchases covered prescription drugs in a calendar year, an amount (not exceeding 50 percent of the applicable limit under subsection (b)) equal to 50 percent of the negotiated price for each such covered prescription drug or such higher percentage as is proposed by a benefit manager pursuant to section 1859G(d)(8), if the Secretary finds that such percentage will not increase aggregate costs to the Insurance Account.

''(b) LIMIT.—

''(1) FOR 2003 THROUGH 2009.—For purposes of subsection (a), the limit under this subsection for 2003 through 2009 is—

''(A) $2,000 for each of calendar years 2003 and 2004;

''(B) $3,000 for each of calendar years 2005 and 2006;

''(C) $4,000 for each of calendar years 2007 and 2008; and

''(D) $5,000 for calendar year 2009.

''(2) FOR 2010 AND SUBSEQUENT YEARS.—For purposes of subsection (a), the limit under this subsection for 2010 and each subsequent year is equal to the greater of the limit for the preceding year adjusted by the percentage change in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the preceding year; or the limit for the preceding year.

''SEC. 1859C. ELIGIBILITY AND ENROLLMENT.

''(a) ELIGIBILITY.—Every individual who, in or after 2003, is entitled to hospital insurance benefits under part A or enrolled in the medical insurance program under part B is eligible to enroll, in accordance with the provisions of this section, in the insurance program under this part, during an enrollment period prescribed in or under this section, in such manner and form as may be prescribed by regulations.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—Each individual who satisfies subsection (a) shall be enrolled (or eligible to enroll) in the program under this part in accordance with the provisions of section 1837, as if that section applied to this part, except as otherwise explicitly provided in this part.

''(2) ENROLLMENT PERIOD.—Except as provided in section 1859E or 1859H, or as otherwise explicitly provided, no individual shall be entitled to enroll in the program under this part at any time after the initial enrollment period.

''(3) SPECIAL ENROLLMENT PERIOD FOR 2003.—

''(A) IN GENERAL.—An individual who first satisfies subsection (a) in 2003 may, at any time on or before December 31, 2003—

''(i) enroll in the program under this part; and

''(ii) enroll or re-enroll in such program after having previously declined or terminated enrollment in such program.

''(B) EFFECTIVE DATE OF COVERAGE.—An individual who enrolls under the program under this part pursuant to subparagraph (A) shall be entitled to benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(e) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as otherwise provided in this part, an individual's coverage under the program under this part shall be effective for the pe-

riod provided in section 1838, as if that section applied to the program under this part.

''(2) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—In addition to the causes of termination specified in section 1838, an individual's coverage under this part shall be terminated when the individual retains coverage under neither the program under part A nor the program under part B, effective on the effective date of termination of coverage under part A or (if later) under part B.

''SEC. 1859D. PREMIUMS.

''(a) ANNUAL ESTABLISHMENT OF MONTHLY PREMIUM RATES.—

''(1) IN GENERAL.—The Secretary shall, during September of 2002 and of each succeeding year, determine and promulgate a monthly premium rate for the succeeding year in accordance with the provisions of this subsection.

''(2) ACTUARIAL DETERMINATIONS.—

''(A) DETERMINATION OF ANNUAL BENEFIT COSTS.—The Secretary shall estimate annually for the succeeding year the amount equal to the total of the benefits that will be payable from the Insurance Account for prescription

drugs dispensed in such calendar year with respect to enrollees in the program under this part. In calculating such amount, the Secretary shall include an appropriate amount for a contingency margin.

''(B) DETERMINATION OF MONTHLY PREMIUM RATES.—

''(i) IN GENERAL.—The Secretary shall determine the monthly premium rate with respect to such enrollees for such succeeding year, which shall be one-twelfth of the share specified in clause (ii) of the amount determined under subparagraph (A), divided by the total number of such enrollees, and rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) ENROLLEE AND EMPLOYER PERCENTAGE SHARES.—The share specified in this clause, for purposes of clause (i), shall be—

''(I) one-half, in the case of premiums paid by an individual enrolled in the program under this part; and

"(II) two-thirds, in the case of premiums paid for such an individual by a former employer (as defined in section 1859H(f)(2)).

"(3) PUBLICATION OF ASSUMPTIONS.—The Secretary shall publish, together with the promulgation of the monthly premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under paragraphs (1) and (2).

"(b) PAYMENT OF PREMIUMS.—

"(1) PAYMENTS BY DEDUCTION FROM SOCIAL SECURITY, RAILROAD RETIREMENT BENEFITS, OR BENEFITS ADMINISTERED BY OPM.—

"(A) DEDUCTION FROM BENEFITS.—In the case of an individual who is entitled to or receiving benefits as described in subsection (a), (b), or (d) of section 1840, premiums payable under this part shall be collected by deduction from such benefits at the same time and in the same manner as premiums payable under part B are collected pursuant to section 1840.

"(B) TRANSFERS TO INSURANCE ACCOUNT.—The Secretary of the Treasury shall,

from time to time, but not less often than quarterly, transfer premiums collected pursuant to subparagraph (A) to the Insurance Account from the appropriate funds and accounts described in subsections (a)(2), (b)(2), and (d)(2) of section 1840, on the basis of the certifications described in such subsections. The amounts of such transfers shall be appropriately adjusted to the extent that prior transfers were too great or too small.

''(2) DIRECT PAYMENTS TO SECRETARY.—

''(A) ADDITIONAL PAYMENT BY ENROLLEE.—An individual to whom paragraph (1) applies (other than an individual receiving benefits as described in section 1840(d)) and who estimates that the amount that will be available for deduction under such paragraph for any premium payment period will be less than the amount of the monthly premiums for such period may (under regulations) pay to the Secretary the estimated balance, or such greater portion of the monthly premium as the individual chooses.

''(B) PAYMENTS BY OTHER ENROLLEES.—An individual enrolled in the insurance program

under this part with respect to whom none of the preceding provisions of this subsection applies (or to whom section 1840(c) applies) shall pay premiums to the Secretary at such times and in such manner as the Secretary shall by regulations prescribe.

''(C) DEPOSIT OF PREMIUMS.—Amounts paid to the Secretary under this paragraph shall be deposited in the Treasury to the credit of the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund.

''(d) CERTAIN LOW-INCOME INDIVIDUALS.—For rules concerning premiums for certain low-income individuals, see section 1859E.

''SEC. 1859F. PRESCRIPTION DRUG INSURANCE ACCOUNT.

''(a) IN GENERAL.—There is created within the Federal Supplemental Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Insurance Account' (hereafter in this section referred to as the 'Account'). The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Funds provided under this part to the Account shall

be kept separate from all other funds within the Federal Supplemental Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g).

''SEC. 1859G. ADMINISTRATION OF BENEFITS.

''(a) IN GENERAL.—The Secretary shall provide for administration of the benefits under this part through a contract with a benefit manager designated in accordance with subsection (c), for enrolled individuals residing in each service area designated pursuant to subsection (b) (other than such individuals enrolled in a Medicare+Choice program under part C), in accordance with the provisions of this section.

''(b) DESIGNATION OF SERVICE AREAS.—

''(1) IN GENERAL.—The Secretary shall divide the total geographic area served by the programs under this title into at least fifteen service areas for purposes of administration of benefits under this part. Such division shall not be subject to administrative or judicial review.

''(2) CONSIDERATIONS.—In determining or adjusting the number and boundaries of service areas under this subsection, the Secretary shall seek to ensure that—

''(A) there is a reasonable expectation of a meaningful level of competition among entities eligible to contract to provide the benefit management services under this section for each area; and

''(B) the designation of areas is consistent with the goal of securing contracts under this section with respect to the maximum feasible number of areas so designated.

''(c) DESIGNATION OF BENEFIT MANAGER.—

''(1) AWARD AND DURATION OF CONTRACT.—The following shall apply to the award of a contract under this subsection with respect to a service area:

''(A) COMPETITIVE AWARD.—Each contract shall be awarded competitively in accordance with section 5 of title 41, United States Code, for a period (subject to subparagraph (B)) of not less than three nor more than five years.

''(B) NONCOMPETITIVE EXTENSION.—The second and each succeeding contract for a serv-

ice area may be extended noncompetitively, at the discretion of the Secretary, for a total contract period not to exceed five years.

''(2) ELIGIBLE ENTITIES.—An entity eligible for consideration as a benefit manager for a service area shall meet at least the following criteria:

''(A) TYPE.—The entity shall be any entity that the Secretary determines is capable of administering a prescription drug benefit program.

''(B) PERFORMANCE CAPABILITY.—The entity shall have sufficient expertise, personnel, and resources to perform effectively the benefit administration functions for such area.

''(C) INTEGRITY; FISCAL SOUNDNESS.—The entity and its officers, directors, agents, and managing employees shall have a satisfactory record of professional competence and professional and financial integrity, and the entity shall have financial resources the Secretary determines to be adequate to perform services under the contract without risk of insolvency.

''(3) PROPOSAL REQUIREMENTS.—An entity's proposal for award or renewal of a contract under this section shall—

''(A) include a cost proposal setting forth the entity's proposed charges for administration of the prescription drug benefit;

''(B) include a proposal for the prices of drugs and annual increases in such prices, including differentials between formulary and non-formulary prices, if applicable (and at the entity's election, include a proposal described in subsection (d)(8));

''(C) specify details of proposed cost and utilization management, error reduction, and quality assurance measures;

''(D) be accompanied by such information as the Secretary may require on the entity's past performance;

''(E) disclose ownership and shared financial interests with other entities involved in the delivery of the benefit as proposed;

''(F) include a proposal for working with the Secretary to deter medical errors related to prescription drugs; and

"(G) include such other material and information as the Secretary may require.

"(4) CRITERIA FOR COMPETITIVE SELECTION.—In awarding a contract competitively, the Secretary shall consider the comparative merits of each of the applications by eligible entities, as determined on the basis of the entities' past performance and other relevant factors, with respect to the following:

"(A) the estimated total cost of the contract, taking into consideration the entity's proposed fees and price and cost estimates, as evaluated and adjusted by the Secretary in accordance with the provisions of the Federal Acquisition Regulation concerning contracting by negotiation;

"(B) prior experience in administering a prescription drug benefit program;

"(C) effectiveness in containing costs through pricing incentives and utilization management;

"(D) the quality and efficiency of benefit management services with respect to such matters as claims processing and benefits coordination; record-keeping and reporting; and drug

utilization review, patient information, and other activities supporting quality of care; and

''(E) such other factors as the Secretary deems necessary to evaluate the merits of each application.

''(5) EXCEPTIONS TO CONFLICT OF INTEREST RULES.—In awarding contracts under this subsection, the Secretary may waive conflict of interest rules generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the purposes of the programs under this title and the best interests of enrolled individuals; and

''(B) will permit a sufficient level of competition for such contracts, promote efficiency of benefits administration, or otherwise serve the objectives of the program under this part.

''(6) MAXIMIZING COMPETITION.—In awarding contracts under this section, the Secretary shall give consideration to the need to maintain sufficient numbers of entities eligible and willing to administer benefits under this part to ensure vigorous competition for such contracts.

"(d) FUNCTIONS OF BENEFIT MANAGER.—The benefit manager for a service area shall (or in the case of the function described in paragraph (8), may) perform some or all of the following functions, as specified by the Secretary:

"(1) PARTICIPATION AGREEMENTS, PRICES, AND FEES.—

"(A) SCHEDULE OF COVERED DRUG PRICES.—Establish, through negotiations with drug manufacturers and wholesalers and pharmacies, a schedule of prices for covered prescription drugs. Such negotiated prices shall not be subject to administrative or judicial review.

"(B) AGREEMENTS WITH PHARMACIES.—Enter into participation agreements under subsection (e) with qualifying pharmacies, on terms that—

"(i) secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access); and

"(ii) permit the participation of any pharmacy in the service area that meets the participation requirements described in subsection (e).

''(C) LISTS OF PRICES AND PARTICIPATING PHARMACIES.—Ensure that the negotiated prices established under subparagraph (A) and the list of pharmacies with agreements under subsection (e) are regularly updated and readily available in the service area to health care professionals authorized to prescribe drugs, participating pharmacies, and enrolled individuals.

''(2) TRACKING OF COVERED ENROLLED INDIVIDUALS.—Maintain accurate, updated records of all enrolled individuals residing in the service area (other than individuals enrolled in a plan under part C).

''(3) PAYMENT AND COORDINATION OF BENEFITS.—

''(A) IN GENERAL.—Administer claims for payment of benefits under this part; determine amounts of benefit payments to be made; and receive, disburse, and account for funds used in making such payments, including through the activities specified in the provisions of this paragraph.

''(B) COORDINATION AND PAYMENT OF BENEFITS.—Coordinate with the Secretary, other benefit managers, pharmacies and other

relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals, including coordination of access to and payment for covered prescription drugs according to an individual's in-service area plan provisions, when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

''(C) EXPLANATION OF BENEFITS.—Furnish to enrolled individuals an explanation of benefits in accordance with section 1806(a), and a notice of the balance of benefits remaining for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(4) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—Have in place effective cost and utilization management, quality assurance measures, and systems to reduce medical errors, including at least the following, together with such additional measures as the Secretary may specify:

''(A) DRUG UTILIZATION REVIEW.—A drug utilization review program conforming to the

standards provided in section 1927(g)(2) (with such modifications as the Secretary finds appropriate for operation of such program by an entity other than a State).

''(B) FRAUD AND ABUSE CONTROL.—Activities to control fraud, abuse, and waste.

''(5) EDUCATION AND INFORMATION ACTIVITIES.—Have in place mechanisms for disseminating educational and informational materials to enrolled individuals and health care providers designed to encourage effective and cost-effective use of prescription drug benefits and to ensure that enrolled individuals understand their rights and obligations under the program.

''(6) BENEFICIARY PROTECTIONS.—

''(A) CONFIDENTIALITY OF HEALTH INFORMATION.—Have in effect systems to safeguard the confidentiality of health care information on enrolled individuals, which comply with section 1106 and with section 552a of title 5, United States Code, and meet such additional standards as the Secretary may prescribe.

''(B) GRIEVANCE AND APPEAL PROCEDURES.—Have in place such procedures as the

Secretary may specify for hearing and resolving grievances and appeals brought by enrolled individuals against the benefit manager or a pharmacy concerning benefits under this part, which shall, to the extent the Secretary finds necessary and appropriate, include procedures equivalent to those specified in subsections (f) and (g) of section 1852.

''(7) RECORDS, REPORTS, AND AUDITS OF BENEFIT MANAGERS.—

''(A) RECORDS AND AUDITS.—Maintain adequate records, and afford the Secretary access to such records (including for audit purposes).

''(B) REPORTS.—Make such reports and submissions of financial and utilization data as the Secretary may require taking into account standard commercial practices.

''(8) PROPOSAL FOR ALTERNATIVE COINSURANCE AMOUNT.—At the benefit manager's election, provide a proposal for increased Government cost sharing for generic prescription drugs, prescription drugs on the benefit manager's formulary, or prescription drugs obtained through mail order pharmacies, which includes evidence that such increased

cost sharing would not result in an increase in aggregate costs to the Account including an analysis of differences in projected drug utilization patterns by beneficiaries whose cost sharing would be reduced under the proposal and those making the cost-sharing payments that would otherwise apply.

''(9) OTHER REQUIREMENTS.—Meet such other requirements as the Secretary may specify.

''(e) PHARMACY PARTICIPATION AGREEMENTS.—

''(1) IN GENERAL.—A pharmacy that meets the requirements of this subsection shall be eligible to enter an agreement with a benefit manager to furnish covered prescription drugs to enrolled individuals residing in the service area.

''(2) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and requirements:

''(A) LICENSING.—The pharmacy shall meet (and throughout the contract period will continue to meet) all applicable State and local licensing requirements.

''(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Secretary and the benefit manager shall establish concerning the quality of, and enrolled

individuals' access to, pharmacy services under this part.

"(C) ADHERENCE TO ESTABLISHED PRICES.—The total charge for each drug dispensed to an enrolled individual, without regard to whether such individual is financially responsible for any or all of such charge, shall not exceed the negotiated price for the drug, as established under subsection (d)(1)(A) with respect to the service area in which the enrolled individual resides.

"(D) MANAGEMENT SYSTEMS AND PROCEDURES.—The pharmacy shall—

"(i) have in effect management systems (including electronic systems) and procedures for carrying out functions under the agreement; and

"(ii) maintain adequate records, afford the benefit manager access to such records for audit purposes, and make such reports as the benefit manager may require to meet its responsibilities under this section.

"(E) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—The pharmacy

shall implement effective measures for quality assurance, cost management, and reduction of medical errors with respect to drugs dispensed under the agreement, including maintenance of utilization records and participation in the drug utilization review program described in subsection (d)(4)(A).

''(F) CONFIDENTIALITY PROTECTIONS.—The pharmacy shall have in effect systems to ensure compliance with the confidentiality standards applicable under subsection (d)(6)(A).

''(G) OTHER REQUIREMENTS.—The pharmacy shall meet such other requirements as the Secretary may impose.

(f) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of benefit managers and their officers, employees, and agents under a contract under this section.

(g) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary is authorized to include in a contract awarded under subsection (c)(4) such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate, including—

''(1) bonus and penalty incentives to encourage administrative efficiency;

''(2) incentives under which benefit managers share in any benefit savings achieved;

''(3) risk sharing arrangements related to benefit payments; and

''(4) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization.

''(h) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG BENEFIT MANAGERS.—During the period after the Secretary has given notice of intent to terminate a contract under subsection (c)(4), the Secretary may transfer responsibilities of the benefit manager under such contract to another benefit manager.

''(i) NONINTERFERENCE.—Nothing in this section or in this part shall be construed as authorizing the Secretary to authorize a particular formulary or to institute a price structure for benefits, or to otherwise interfere with the competitive nature of providing a prescription drug benefit through benefit managers.

"SEC. 1859H. EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT–BASED RETIREE DRUG COVERAGE.

''(a) PROGRAM AUTHORITY.—The Secretary is authorized to develop and implement a program under this section called the Employer Incentive Program that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (f)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered retirees—

''(i) at least 120 days before terminating its plan, and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the insurance benefit under this part.

''(2) BENEFICIARY INFORMATION.—The sponsor shall report to the Secretary, for each calendar quarter for which it seeks an incentive payment under this section the names and social security numbers of all retirees (and their spouses and dependents) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(3) AUDITS.—The sponsor and the employment-based retiree health coverage plan seeking incentive payments under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of incentive payments made, and such other matters as may be appropriate.

''(4) OTHER REQUIREMENTS.—The sponsor shall provide such other information, and comply with such other requirements, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENT.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined as described in paragraph (2), for each retired individual (or spouse) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for but was not enrolled in the insurance program under this part.

''(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to two-thirds of the monthly premium amount pay-

able by an enrolled individual, as set for the calendar year pursuant to section 1859D(a)(2).

''(3) PAYMENT DATE.—The incentive under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to three times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) PART D ENROLLMENT FOR CERTAIN INDIVIDUALS COVERED BY EMPLOYMENT-BASED RETIREE HEALTH COVERAGE PLANS.—

''(1) ELIGIBLE INDIVIDUALS.—An individual shall be given the opportunity to enroll in the program under this part during the period specified in paragraph (2) if—

''(A) the individual declined enrollment in the program under this part at the time the individual first satisfied section 1859C(a);

''(B) at that time, the individual was covered under a qualified retiree prescription drug plan for which an incentive payment was paid under this section; and

''(C)(i) the sponsor subsequently ceased to offer such plan; or

''(ii) the value of prescription drug coverage under such plan became less than the value of the coverage under the program under this part.

''(2) SPECIAL ENROLLMENT PERIOD.—An individual described in paragraph (1) shall be eligible to enroll in the program under this part during the six-month period beginning on the first day of the month in which—

''(A) the individual receives a notice that coverage under such plan has terminated (in the circumstance described in paragraph (1)(C)(i)) or notice that a claim has been denied because of such a termination; or

''(B) the individual received notice of the change in benefits (in the circumstance described in subparagraph (1)(C)(ii)).

''(f) DEFINITIONS.—As used in this section, terms have the following meanings:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(2) EMPLOYER.—The term 'employer' has the meaning given such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of two or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs whose actuarial value (as defined by the Secretary) to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any

health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' means plan sponsor as defined in section 3(16) of the Employer Retirement Income Security Act of 1974.

(g) APPROPRIATIONS TO COVER INCENTIVES FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated such sums as may be necessary for payment of incentive payments under subsection (c).

''SEC. 1859I. APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.

''There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Prescription Drug Insurance Account, a Government contribution equal to—

''(1) the aggregate premiums payable for a month pursuant to section 1859D(a)(2) by individuals enrolled in the program under this part, plus

''(2) one-half the aggregate premiums payable for a month pursuant to such section for such individuals by former employers.

"SEC. 1859J. DEFINITION.

''As used in this part, the term 'prescription drug' means—

''(1) a drug that may be dispensed only upon a prescription, and that is described in subparagraph (A)(i), (A)(ii), or (B) of section 1927(k)(2); and

''(2) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act, and needles, syringes, and disposable pumps for the administration of such insulin.''.

(b) STUDY OF ANNUAL OPEN ENROLLMENT.—During 2003 and 2004, the Secretary shall study the feasibility and advisability of establishing an annual open enrollment period for the program under part D (as added by subsection (a)). Such study shall reflect data reported by benefit managers administering benefits under such part and shall include:

(1) a review of the costs, effectiveness, and administrative feasibility of an annual open enrollment period for beneficiaries who previously declined enrollment or who previously disenrolled and desire to re-enroll;

(2) an evaluation of a premium penalty for late enrollment based on actuarially determined costs to the program of late enrollment; and

(3) a projection of the costs to the program under such part through 2010 of an annual open enrollment period.

The Secretary shall prepare a report setting forth the outcome of the study, and may include in the report a recommendation as to whether an annual open enrollment period should be implemented under such part.

(c) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO FEDERAL SUPPLEMENTARY HEALTH INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

(A) in the last sentence of subsection (a)—

(i) by striking ''and such amounts'' and replacing it with ''such amounts''; and

(ii) by adding the following before the period: ''and such amounts as may be deposited in, or appropriated to, the Prescription Drug Insurance Account established by section 1859F'';

(B) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund),'';

(C) in subsection (h), by adding at the end of the first sentence: ''and section 1859D(b)(4) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund)''; and

(D) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section 1859D(b)(2) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund),''.

(2) PRESCRIPTION DRUG OPTION UNDER MEDICARE+CHOICE PLANS.—

(A) Section 1851 (42 U.S.C. 1395w–21) is amended—

(i) in subsection (a)(1)(A), by striking ''parts A and B'' and inserting ''parts A, B, and D''; and

(ii) in subsection (i), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(B) Section 1852(a)(1)(A) (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting

''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(C) Section 1852(d)(1) (42 U.S.C. 1395(d)(1)) is amended—

(i) by striking ''and'' at the end of subparagraph (D);

(ii) by striking the period at the end of subparagraph (E) and inserting ''; and'' and

(iii) by adding at the end the following new subparagraph:

''(F) the plan for part D benefits guarantees coverage of any specifically named covered prescription drug for an enrollee, when prescribed by a physician in accordance with the provisions of such part, regardless of whether such drug would otherwise be covered under an applicable formulary or discount arrangement.''.

(D) Section 1854(e) (42 U.S.C. 1395w–4(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PROVISION OF PART D BENEFITS.—In no event may a Medicare+Choice organization include as part of a plan for part D bene-

fits a requirement that an enrollee pay a deductible, or a coinsurance percentage that exceeds 50 percent.

(E) Section 1857(d) (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

''(6) AVAILABILITY OF NEGOTIATED PRICES.—Each contract under this section shall provide that enrollees who exhaust the plan's prescription drug benefits will continue to have access to prescription drugs at negotiated prices equivalent to the total combined cost of such drugs to the plan and the enrollee prior to such exhaustion of benefits.''.

(3) EXCLUSIONS FROM COVERAGE.—

(A) APPLICATION TO PART D.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(B) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(i) by striking ''and'' at the end of subparagraph (H);

(ii) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(iii) by adding after subparagraph (I) the following new subparagraph:

"(J) in the case of prescription drugs covered under part D, which are not prescribed in accordance with such part;

SEC. 202. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION DRUG COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) STATE OPTION TO BUY-IN DUALLY ELIGIBLE INDIVIDUALS.—

(1) COVERAGE OF PREMIUMS AS MEDICAL ASSISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended in the fourth sentence by striking "under part B" the first place it appears and inserting "under parts B and D".

(2) STATE COMMITMENT TO CONTINUE PARTICIPATION IN PART D AFTER BENEFIT LIMIT REACHED.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking "and" at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(C) by adding after paragraph (65) the following new paragraph:

''(66) that, in the case of any individual whose eligibility for medical assistance is not limited to Medicare or Medicare drug cost sharing and for whom the State elects to pay premiums under part D of title XVIII pursuant to section 1859E, the State will purchase all prescription drugs for such individual in accordance with the provisions of such part D, without regard to whether the benefit limit for such individual under section 1859B(b) has been reached.''.

(b) MEDICARE COST SHARING REQUIRED FOR QUALIFIED MEDICARE BENEFICIARIES.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and'' at the end of clause (i);

(B) by inserting ''and'' at the end of clause (ii); and

(C) by adding after clause (ii) the following:

"(iii) premiums under section 1859D,";

(2) in subparagraph (D)—

(A) by inserting "(i)" after "(D)"; and

(B) by adding at the end the following:

"(ii) The difference between the amount that is paid under section 1859B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if any reference to such percentage were deemed to be multiplied by two).

(c) MEDICARE DRUG COST SHARING REQUIRED FOR MEDICARE-ELIGIBLE INDIVIDUALS WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

(1) DEFINITIONS OF ELIGIBLE BENEFICIARIES AND COVERAGE.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(v)(1) The term 'qualified medicare drug beneficiary' means an individual—

"(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an indi-

vidual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),

''(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (p)(2)(D)) is above 100 percent but below 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

''(2) The term 'medicare drug cost-sharing' means the following costs incurred with respect to a qualified medicare drug beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

''(A) In the case of a qualified medicare drug beneficiary whose income (as determined under

paragraph (1)) is less than 135 percent of the official poverty line—

"(i) premiums under section 1859D; and

"(ii) the difference between the amount that is paid under section 1859B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if any reference to such percentage were deemed to be multiplied by two).

"(B) In the case of a qualified medicare drug beneficiary whose income (as determined under paragraph (1)) is at least 135 percent but less than 150 percent of the official poverty line, a percentage of premiums under section 1859D, determined on a linear sliding scale ranging from 100 percent for individuals with incomes at 135 percent of such line to 0 percent for individuals with incomes at 150 percent of such line.

"(3) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such

requirement if the State had in effect a plan approved under this title.''.

(2) STATE PLAN REQUIREMENT.—Section 1902(a)(10)(E) (42 U.S.C. 1396(a)(10)(E)) is amended—

(A) by striking ''and'' at the end of clause (iii);

(B) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare drug cost sharing (as defined in section 1905(v)(2)) for qualified medicare drug beneficiaries described in section 1905(v)(1); and''.

(3) 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE DRUG COST SHARING.—Section 1903(a) (42 U.S.C. 1396b(a)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by adding after paragraph (6) the following new paragraph:

''(7) an amount equal to 100 percent of amounts as expended as medicare drug cost sharing for qualified medicare drug beneficiaries (as defined

in section 1905(v)) (except that this paragraph shall not apply to amounts expended with respect to any individual whose eligibility for medical assistance is not limited to medicare or medicare drug cost sharing); and''.

(d) MEDICAID DRUG PRICE REBATES UNAVAILABLE WITH RESPECT TO DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—Section 1927 (42 U.S.C. 1396r–8) is amended by adding at the end the following new subsection:

''(l) DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—The provisions of this section shall not apply to prescription drugs purchased under part D of title XVIII pursuant to an agreement with the Secretary under section 1859E (including any drugs so purchased after the limit under section 1859B(b) has been exceeded).''.

(e) AMENDMENTS TO MEDICARE PART D.—Part D of title XVIII, as added by section 201, is amended by adding after section 1859D the following new section:

''SEC. 1859E. SPECIAL ELIGIBILITY, ENROLLMENT, AND CO-PAYMENT RULES FOR LOW-INCOME INDIVIDUALS.

''(a) STATE AGREEMENTS FOR COVERAGE.—

''(1) IN GENERAL.—The Secretary shall, at the request of a State, enter into an agreement with the State under which all individuals described in paragraph (2) are enrolled in the program under this part, without regard to whether any such individual has previously declined the opportunity to enroll in such program.

''(2) ELIGIBILITY GROUPS.—The individuals described in this paragraph, for purposes of paragraph (1), are individuals who satisfy section 1859C(a) and who are—

''(A)(i) eligible individuals within the meaning of section 1843, and

''(ii) in a coverage group or groups permitted under section 1843 (as selected by the State and specified in the agreement); or

''(B) qualified medicare drug beneficiaries (as defined in section 1905(v)(1)).

''(3) COVERAGE PERIOD.—The period of coverage under this part of an individual enrolled under an agreement under this subsection shall be as follows:

''(A) INDIVIDUALS ELIGIBLE (AT STATE OPTION) FOR PART B BUY-IN.—In the case of an individual described in subsection (a)(2)(A),

the coverage period shall be the same period that applies (or would apply) pursuant to section 1843(d).

''(B) QUALIFIED MEDICARE DRUG BENEFICIARIES.—In the case of an individual described in subsection (a)(2)(B)—

''(i) the coverage period shall begin on the latest of—

''(I) January 1, 2003,

''(II) the first day of the third month following the month in which the State agreement is entered into; or

''(III) the first day of the first month following the month in which the individual satisfies section 1859C(a); and

''(ii) the coverage period shall end on the last day of the month in which the individual is determined by the State to have become ineligible for medicare drug cost-sharing.

''(b) SPECIAL PART D ENROLLMENT OPPORTUNITY FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In the case of an individual who—

''(1) satisfies section 1859C(a), and

''(2) loses eligibility for benefits under the State plan under title XIX after having been enrolled under such plan or having been determined eligible for such benefits,

the Secretary shall provide an opportunity for enrollment under the program under this part during the period that begins on the date that such individual loses such eligibility and ends on the date specified by the Secretary.

''(c) DEFINITION.—For purposes of this section, the term 'State' has the meaning given such term under section 1101(a) for purposes of title XIX.''.

PART B—IMPROVING PREVENTIVE BENEFITS AND ELIMINATING COST SHARING

SEC. 221. ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR PREVENTIVE BENEFITS.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding after subsection (o) the following new subsection:

''(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR PREVENTIVE BENEFITS.—Deductibles and coinsurance under subsections (a) and (b) shall not be required of individuals covered under the insurance program under this part for any of the following preventive health care items and services:

''(1) blood-testing strips, lancets, and blood glucose monitors for individuals with diabetes described in section 1861(n);

''(2) diabetes outpatient self-management training services described in section 1861(s)(2)(S);

''(3) pneumococcal, influenza, and hepatitis B vaccines and administration described in section 1861(s)(10) ;

''(4) screening mammography as described in section 1861(s)(13);

''(5) screening pap smear and screening pelvic examinations as described in section 1861(s)(14);

''(6) bone mass measurement as described in section 1861(s)(15);

''(7) prostate cancer screening tests as defined in section 1861(oo); and

''(8) colorectal cancer screening as defined in section 1861(pp)(1).''.

(b) WAIVER OF COINSURANCE.—Section 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive care items and services described in subsection (p)''.

(c) WAIVER OF DEDUCTIBLE.—Section 1833(b) (42 U.S.C. 1395l(b)) is amended in clause (1) to read as fol-

lows: ''(1) such deductible shall not apply with respect to preventive health care items and services specified in subsection (p)''.

(d) ADDING ''LANCET'' TO DEFINITION OF DME.—Section 1861(n) (42 U.S.C. 1395x(n)) is amended by striking ''blood-testing strips and blood glucose monitors'' and inserting ''blood-testing strips, lancets, and blood glucose monitors ''.

(e) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (B)—

(i) by striking ''section 1861(s)(10)(A)'' and inserting ''section 1833(p)''; and

(ii) by striking ''reasonable charges'' and inserting ''of the fee schedule or other basis of payment under this title''; and

(B) in subparagraphs (1)(D)(i) and (2)(D)(i), by inserting ''described in subsection (p) or'' after ''in the case of such tests''.

(2) Section 1834(a)(1)(A) (42 U.S.C. 1395m(a)(1)(A)) is amended by inserting ''(or 100 percent, in the case of such an item described in section 1833(p))'' after ''80 percent''.

(3) Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ''80 percent'' and inserting ''100 percent''.

(4) Section 1834(d) (42 U.S.C. 1395m(d)) is amended—

(A) in each of paragraphs (2)(C) and (3)(C)—

(i) by striking clause (ii); and

(ii) by striking all that precedes ''subsections (i)(2)(A) and (t)'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding'', and adjusting margins accordingly; and

(B) in paragraph (2)(C), by redesignating subclauses (I) and (II) as clauses (i) and (ii).

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective on and after January 1, 2003.

SEC. 222. INFORMATION CAMPAIGN ON PREVENTION.

(a) REQUIRED ACTIVITIES.—The Secretary of Health and Human Services shall carry out, during 2002 and 2003, a nationwide education campaign to promote preventive health awareness among older Americans and

people with disabilities, which shall include the following activities:

(1) An information campaign, in collaboration with the Social Security Administration, State health insurance assistance programs, area agencies on aging, and the private sector, designed to educate all Americans over age 50 and individuals with disabilities about the importance of preventive health care.

(2) Activities designed to encourage Medicare beneficiaries to use Medicare preventive benefits, including distribution of comprehensive information on Medicare preventive benefits to all Medicare beneficiaries.

(3) Development and testing of a health status assessment tool with follow-up interventions, to assist Medicare beneficiaries and their providers in identifying and mitigating health risks.

(4) A nationwide education and awareness campaign designed to educate older Americans on adjustments to behavior and the home environment that can prevent falls.

(b) AUTHORIZATION OF APPROPRIATIONS.—Such sums as may be necessary to carry out this section are authorized to be appropriated for fiscal years 2002 and 2003.

SEC. 223. SMOKING CESSATION DEMONSTRATION.

(a) IN GENERAL.—The Secretary shall, either directly or through grants, contracts, or cooperative agreements, carry out a demonstration project testing a variety of smoking cessation services for Medicare beneficiaries, for the purpose of identifying the most successful and cost-effective approaches.

(b) DESIGN OF DEMONSTRATION.—

(1) IN GENERAL.—The Secretary shall determine the design, implementation, and evaluation of the demonstration under this section, subject to the provisions of this section.

(2) SERVICES INCLUDED.—Services under the demonstration may include an initial patient assessment, counseling services, and any pharmacotherapy for smoking cessation approved by the Food and Drug Administration, and such other services as the Secretary may authorize. Services may be furnished by a person or entity that provides other services for which payment may be made under title XVIII of the Social Security Act, as well as by health educators and other professionals in categories designated by the Secretary who meet applicable certification and licensing requirements of State and local law.

(3) SCOPE AND DURATION.—Demonstration projects under this section shall be conducted at a minimum of four sites and shall not exceed five years in duration.

(c) Notwithstanding any provision of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or any other provision of law, in the case of smoking cessation items and services furnished to a Medicare beneficiary under a demonstration conducted by the Secretary under this section by an individual or entity authorized by the Secretary to participate in such demonstration—

(1) Such items and services shall be deemed to be health care items and services covered under the insurance programs under such title XVIII for purposes of payment from the Federal Health Insurance and Federal Supplementary Medical Insurance Trust Funds;

(2) Persons and entities furnishing smoking cessation items and services under a demonstration under this section shall be entitled to be paid from such Trust Funds an amount equal to the lesser of the actual cost of such items and services or the payment amount prescribed for such items or services under a fee schedule established by the Secretary; and

(3) The Secretary shall waive all coinsurance and deductibles under such title XVIII for smoking cessation items and services furnished under such demonstration.

(d) WAIVER AUTHORITY.—The Secretary is authorized to waive the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to the extent and for the period the Secretary finds necessary to conduct the demonstration under this section.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Health Insurance and Federal Supplementary Insurance Trust Fund of such funds as are necessary for the costs of carrying out and evaluating the demonstration projects under this section.

(f) EVALUATION; REPORT TO CONGRESS.—Upon conclusion of the demonstration, the Secretary shall cause the demonstration to be evaluated and shall submit to Congress a report including the following:

(1) A description of the demonstration.

(2) An assessment of—

(A) patient outcomes, including smoking ''quit'' rates;

(B) the cost-effectiveness of the demonstration; and

(C) the quality of the services furnished through the demonstration, including measures of beneficiary and provider satisfaction.

(3) A recommendation as to whether the demonstration should be continued or expanded under part B of such title XVIII, including, if the evaluation has found the demonstration successful, recommendations as to the individuals who should be eligible to receive smoking cessation benefits, the persons and entities that should be authorized to provide the benefits, the type and scope of benefits, and appropriate payment methodologies.

(4) Any other information that the Secretary determines to be appropriate.

PART C—RATIONALIZING COST SHARING AND MEDIGAP

SEC. 231. DEDUCTIBLES AND COINSURANCE FOR CLINICAL LABORATORY SERVICES.

(a) IN GENERAL.—Section 1833, as amended by section 221, is further amended—

(1) in subsection (a)—

(A) in paragraph (1)(D)—

(i) in clause (i), by striking the open parenthesis an all that follows through ''on an assignment-related basis)''; and

(ii) in clause (ii), by striking ''100 percent'' and inserting ''80 percent (or 100 percent, in the case of such tests described in subsection (p))''; and

(B) in paragraph (2)(D)—

(i) in clause (i), by striking the open parenthesis and all that follows through ''section 1866'' and inserting ''such tests described in subsection (p)''; and

(ii) in clause (ii), by striking ''100 percent'' and inserting ''80 percent (or 100 percent, in the case of such tests described in subsection (p))''; and

(2) in subsection (b)—

(A) by striking subparagraph (3); and

(B) by redesignating paragraphs (4) through (6) as paragraphs (3) through (5) respectively.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 2003.

SEC. 232. INDEXING DEDUCTIBLE TO INFLATION.

Section 1833(b) (42 U.S.C. 1395l(b)) is amended by inserting after ''1991 and subsequent years'' the following: '', adjusted annually, effective January 1 of each year be-

ginning in 2003, by a percentage increase or decrease equal to the percentage increase or decrease in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar''.

SEC. 233. UPDATING AND EXPANDING MEDIGAP PLAN OPTIONS.

(a) REVIEW AND UPDATE OF BENEFIT PACKAGES FOR MEDIGAP POLICIES.—

(1) ESTABLISHMENT OF NEW MEDIGAP PLAN.—

(A) IN GENERAL.—Section 1882(p)(1) (42 U.S.C. 1395ss(p)(1)) is amended by redesignating subparagraph (E) as subparagraph (F) and inserting after subparagraph (D) the following new subparagraph:

''(E) (i) Within 9 months after enactment of this subparagraph, the Association may revise the 1991 NAIC Model Regulation to include a new plan 'K' that—

''(I) complies with paragraphs (2) and (3);

''(II) except as provided in subclause (III), requires the beneficiary of the policy to pay—

"(aa) nominal copayments; and

"(bb) all or a portion (not to be less than 50 percent) of the part B deductible under section 1833; and

"(III) in the case of beneficiaries under the policy who are receiving services under any of the programs specified in paragraphs (1) through (4) of section 1866M(a), covers 100 percent of any cost-sharing charges imposed on beneficiaries under such program.

If the Association so revises the 1991 NAIC Model Regulation, references to the 1991 NAIC Model Regulation in this section shall be interpreted to refer to the 1991 NAIC Model Regulation as so revised.

"(ii) If the Association does not make the changes in the revised NAIC Model Regulation within the 9-month period specified in clause (i) the Secretary shall provide for the establishment of a new plan 'K' in accordance with the provisions of subparagraph (B), and any requirements applicable to a State under subparagraph (B) shall apply with respect to the estab-

lishment of the new plan under this subparagraph.''.

(B) REQUIREMENT THAT ALL ISSUERS OFFER PLAN ''K''.—

(i) IN GENERAL.—Section 1882(p)(9)(A) (42 U.S.C. 1395ss(p)(9)(A)) is amended by inserting before the period ''and a medicare supplemental policy described in paragraph (1)(E)''.

(ii) PROHIBITION ON STATE RESTRICTION.—Section 1882(p)(5)(B) (42 U.S.C. 1395ss(p)(5)(B)) is amended by inserting before the period ''or a medicare supplemental policy described in paragraph (1)(E)''.

(C) CONFORMING AMENDMENTS.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended in paragraph (2)(C) by striking ''shall not exceed 10'' and inserting ''shall not exceed 11''.

(2) PERIODIC REVIEW.—Section 1882(p)(1)(F) (42 U.S.C. 1395ss(p)(1)(F)) as redesignated, is amended—

(A) by striking all that precedes ''the preceding provisions of this paragraph'' and inserting the following:

''(F) The Secretary, in consultation with the Association, shall periodically review standard supplemental packages established pursuant to paragraph (2). If, on the basis of such consultation and review, the Secretary determines that changes in the 1991 NAIC Model Regulation or 1991 Federal Regulation (including changes in the content or number of packages established pursuant to paragraph (2), and in the provision or scope of drug benefits available under those packages), are needed to better reflect the needs of beneficiaries under this title (including the need for affordable supplemental insurance options),''; and

(B) by adding at the end the following new sentence: ''If the Secretary determines that it is necessary to change the benefit packages established under paragraph (2) to better reflect the needs of beneficiaries as described in this subparagraph, the Secretary shall, through a notice in the Federal Register, request the Association

to recommend such changes to the benefit package as it considers appropriate.''.

(b) IMPROVED INFORMATION ON MEDIGAP.—Section 1882(e) (42 U.S.C. 1395ss(e)) is amended by adding at the end the following new paragraph:

''(4) The Secretary shall provide to individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) information allowing easy comparison of the supplemental insurance policies authorized under subsection (p)(2), including the benefits, premiums, and cost-sharing provisions of such policies.''.

SEC. 234. REPORT TO CONGRESS ON OPTIONS FOR IMPROVING MEDICARE SUPPLEMENTAL COVERAGE.

(a) IN GENERAL.—The Secretary shall prepare and transmit to the Congress, not later than January 1, 2002, a detailed report that may include specific recommendations on policy options for improving Medicare supplemental coverage, with particular attention to means of limiting out-of-pocket costs for health care items and services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) .

(b) CONTENTS OF REPORT.—The report required under this section may—

(1) consider effects of beneficiaries' having multiple sources of health care coverage (including duplication of coverage and incentives for overutilization of services);

(2) compare total cost sharing by Medicare beneficiaries (under Medicare and Medicare supplemental policies) with cost sharing by beneficiaries of private-sector health insurance;

(3) consider means of improving beneficiary information on the comparative cost and quality of Medicare supplemental policies;

(4) consider options for structuring, and the feasibility and advisability (including the potential for reducing beneficiaries' out-of-pocket costs and unnecessary utilization) of alternatives including—

(A) optional unsubsidized supplemental coverage under Medicare requiring beneficiary cost-sharing; and

(B) a Medicare supplemental benefit, requiring beneficiary copayments, to be offered by private entities as a supplement to coverage under original Medicare as part of the competitive defined benefit program.

SEC. 235. INCREASING ACCESS TO MEDIGAP.

(a) APPLYING MEDIGAP PROTECTIONS TO DISABLED AND ESRD MEDICARE BENEFICIARIES.—

(1) OPEN ENROLLMENT PERIOD FOR DISABLED AND ESRD BENEFICIARIES.—

(A) IN GENERAL.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(i) in paragraph (2)(A), by striking ''the 6 month period'' and all that follows through the period and inserting ''(i) the 6 month period beginning with the first month as of the first day on which the individual is first enrolled for benefits under part B of this subchapter; and (ii) if different from the period specified in clause (i), the 6 month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under such part B.'';

(ii) in paragraph (2)(D), in the matter preceding clause (i)—

(I) by striking ''the 6-month period'' and inserting ''a 6-month period''; and

(II) by striking ''who is 65 years of age or older as of the date of issuance and''; and

(iii) in paragraph (3)(B)(vi), by striking ''at age 65''.

(B) INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)), as amended by subparagraph (A), is amended by adding at the end the following new subparagraph:

''(E) In the case of an individual who, as of the effective date of enactment of this subparagraph, is enrolled for benefits under part B on the basis of disability or end-stage renal disease and has not attained age 65, the 6 month period specified in subparagraph (A)(i) shall be deemed to be the 6 month period beginning on such date.''.

(2) REQUIREMENT THAT MEDIGAP ISSUERS OFFER POLICIES TO DISABLED AND ESRD BENEFICIARIES.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(A) by redesignating paragraph (4) as paragraph (5); and

(B) by adding after paragraph (3) the following new paragraph:

''(4) The issuer of a Medicare supplemental policy that offers such policy to individuals who are 65 years of age or older may not decline to offer such policy to individuals entitled to benefits under this title pursuant to section 226(b) or 226A.''.

(3) RATING STANDARDS FOR POLICIES ISSUED TO DISABLED AND ESRD BENEFICIARIES.—Section 1882(s) (42 U.S.C. 1395ss(s)), as amended by paragraph (2), is amended—

(A) by redesignating paragraph (5) as paragraph (6); and

(B) by adding after paragraph (4) the following new paragraph:

''(5)(A) The Secretary shall request the National Association of Insurance Commissioners (in this paragraph referred to as the 'Association') to develop and publish model standards for rating Medicare supplemental policies for individuals who are under age 65. Such standards shall be designed to ensure affordable access to such policies for such individuals while avoiding, to the greatest extent possible, disruptions in the market for Medicare supplemental policies.''.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1), (2), and (3) are effective 30 days after enactment of this Act.

(b) SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMINATION PROVISION FOR CERTAIN BENEFICIARIES.—

(1) DISENROLLMENT WINDOW IN ACCORDANCE WITH BENEFICIARY'S CIRCUMSTANCE.—Section 1882(s)(3) is amended—

(A) in subparagraph (A), by striking ''not later than 63 days after the date of termination of enrollment described in such subparagraph'' and inserting ''during the period specified in subparagraph (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) For purposes of subparagraph (A), the time period specified in this subsection in the case of an individual—

''(i) described in clause (i) of subparagraph (B), is the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if no such notice is received, notice that a claim has been denied

because of such a termination or cessation and ending 63 days thereafter;

''(ii) described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, is the period beginning on the date that the individual receives a notice of termination and ending on the date 63 days after the date coverage ends;

''(iii) described in clause (iv)(I), is the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that coverage ends, and ending on the date 63 days after the date coverage ends;

''(iv) described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, is the period beginning on the date 60 days before and ending on the date 63 days after, the effective date of disenrollment; and

''(v) described in subparagraph (B), but not described in the preceding provi-

sions of this subparagraph, is the period beginning on the effective date of disenrollment and ending on the date 63 days thereafter.''.

(2) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED TRIAL PERIODS.—Section 1882(s)(3), as amended by paragraph (1), is further amended by adding at the end the following new subparagraph:

''(F) For purposes of this paragraph—

''(i) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization described in subparagraph (B)(v)(II) is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause (v); and

''(ii) in the case of an individual described in subparagraph (B)(vi) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a

plan described in subparagraph (B)(v)(II) is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause (vi).''.

(c) ONE-TIME ADDITIONAL SPECIAL OPEN ENROLLMENT FOR BENEFICIARIES LOSING ACCESS TO MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—An issuer of a medicare supplemental policy must comply with the conditions of clauses (i) through (iii) of section 1882(s)(3)(A) in the case of an individual described in paragraph (2) who seeks to enroll under the policy not later than 92 days after the date of enactment of this section.

(2) CONDITIONS OF ELIGIBILITY.—

(A) IN GENERAL.—For purposes of paragraph (1), an individual is described in this paragraph if—

(i) the individual's enrollment with an organization—

(I) described in clause (i) or (ii) of subparagraph (B) is terminated be-

cause of a circumstance described in section 1851(e)(4)(A); or

(II) described in clause (iii) of subparagraph (B) is terminated on or before December 31, 1998 because of such a circumstance;

(ii) the individual is not enrolled—

(I) with another organization described in subparagraph (B); or

(II) under a medicare supplemental policy; and

(iii) the individual submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) APPLICABLE ORGANIZATIONS.—For purposes of subparagraph (A), an organization described in this subparagraph is—

(i) an eligible organization under a contract under section 1876 or a similar organization operating under a demonstration project authority;

(ii) an organization under an agreement under section 1833(a)(1)(A); or

(iii) a Medicare+Choice organization under a Medicare+Choice plan under part C.

(d) GUARANTEED ACCESS FOR CERTAIN MEDICARE BENEFICIARIES TO ALL SUPPLEMENTAL POLICIES.—Section 1882(s)(3)(C)(iii) (42 U.S.C. 1395ss(s)(3)(C)(iii)) is amended by inserting ''or an individual described in subparagraph (B)(ii) or (B)(iii) in the case of circumstances permitting discontinuance of the individual's election under section 1851(e)(4)(A)'' after ''subparagraph(B)(vi)''.

(e) INCREASED CIVIL MONEY PENALTIES FOR VIOLATION OF OPEN ENROLLMENT REQUIREMENT.—Section 1882(s)(4) (42 U.S.C. 1395ss(s)(4)) is amended by striking ''the requirements of this subsection is subject to a civil money penalty of not to exceed $5,000 for each such failure'' and inserting ''any requirement of this subsection with respect to any individual is subject to a civil money penalty of not to exceed $50,000 for each such failure with respect to such individual, plus an additional civil money penalty of not to exceed $5,000 for each day such failure continues with respect to such individual''.

(f) TRANSITION PROVISIONS.—The provisions of section 4031(e) of the Balanced Budget Act of 1997 shall

apply to the amendments made by this section in the same manner as they apply to such section 4031, except that—

(1) the reference in such section 4031(e) to ''9 months after the date of the enactment of this Act'' shall be considered to be a reference to 9 months after the effective date of this section;

(2) the reference in such section 4031(e) to the ''1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191)'' shall be considered to be a reference to the 1991 NAIC Model Regulation, as modified pursuant to all statutes enacted prior to the enactment of this section; and

(3) any reference to ''1999'' in such section 4031(e) shall be considered to be a reference to 2002 for purposes of the amendments made by this section.

SEC. 236. REMOVAL OF SUNSET DATE FOR COST-SHARING IN MEDICARE PART B PREMIUMS FOR CERTAIN QUALIFYING INDIVIDUALS.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended—

(1) by striking subclause (II);

(2) by amending the text preceding subclause (I) to read as follows:

"(iv) subject to section 1905(p)(4), for making medical assistance available";

(3) by striking subclause designation "(I)", relocating the remaining text at the end of clause (iv), and indenting appropriately; and

(4) by striking ", and" at the end of clause (iv), as so amended, and inserting "; and".

(b) RELOCATION OF PROVISION REQUIRING 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR CERTAIN QUALIFYING INDIVIDUALS.—Section 1903(a) (42 U.S.C. 1395b(a)), as amended by section 202(c)(3), is amended—

(1) by redesignating paragraph (8) as paragraph (9); and

(2) by adding after paragraph (7) the following new paragraph:

"(8) an amount equal to 100 percent of amounts as expended as medicare drug cost sharing

for individuals described in section 1903(a)(10)(E)(iv);''.

(c) REPEAL OF SECTION 1933.—Section 1933 (42 U.S.C. 1396u–3) is repealed.

(d) EFFECTIVE DATE.—The amendments made by this section shall be effective on and after January 1, 2003.

TITLE III—PROTECTING AND EXTENDING MEDICARE SOLVENCY

SEC. 301. TRANSFERS TO EXTEND MEDICARE SOLVENCY.

Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(l) Additional Appropriation to Federal Hospital Insurance Trust Fund.—

''(1) In addition to any other amounts appropriated to the Trust Fund, there is hereby appropriated to the Trust Fund, out of any moneys in the Treasury not otherwise appropriated—

''(A) for the fiscal year ending September 30, 2001, $15,400,000,000;

''(B) for the fiscal year ending September 30, 2002, $12,600,000,000;

''(C) for the fiscal year ending September 30, 2006, $26,000,000,000;

"(D) for the fiscal year ending September 30, 2007, $47,000,000,000;

"(E) for the fiscal year ending September 30, 2008, $57,000,000,000;

"(F) for the fiscal year ending September 30, 2009, $61,000,000,000;

"(G) for the fiscal year ending September 30, 2010, $80,000,000,000;

"(H) for the fiscal year ending September 30, 2011, $22,400,000,000;

"(I) for the fiscal year ending September 30, 2012, $29,500,000,000;

"(J) for the fiscal year ending September 30, 2013, $32,000,000,000;

"(K) for the fiscal year ending September 30, 2014, $26,200,000,000;

"(L) for the fiscal year ending September 30, 2015, $13,800,000,000.

"(2) The amounts appropriated for each fiscal year by paragraph (1) shall be transferred from the general fund in the Treasury to the Trust Fund in equal monthly installments on the first business day of each month.".

SEC. 302. CATASTROPHIC PRESCRIPTION DRUG COVERAGE RESERVE.

(a) ESTABLISHMENT OF RESERVE.—There is established a reserve fund which shall be known as the ''Catastrophic Prescription Drug Coverage Reserve,'' as defined in section 3(11) of the Congressional Budget Act of 1974, as amended by this Act.

(b) DEFINITION.—Section 3 of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''(11) The term 'Catastrophic Prescription Drug Coverage Reserve' means—

''(A) for fiscal year 2006, $4,000,000,000;

''(B) for fiscal year 2007, $5,000,000,000;

''(C) for fiscal year 2008, $6,800,000,000;

''(D) for fiscal year 2009, $8,400,000,000; and

''(E) for fiscal year 2010, $10,800,000,000.''.

(c) DISPOSITION OF RESERVE FUND.—Beginning with September 30, 2006, any balance remaining in the Catastrophic Prescription Drug Coverage Reserve on the last day of a fiscal year is appropriated to the Federal Hospital Insurance Trust Fund.

SEC. 303. MEDICARE SOLVENCY DEBT REDUCTION RESERVE.

(a) IN GENERAL.—Both the transfers under section 1817(1) of the Social Security Act as well as amounts placed in reserve for catastrophic prescription drug coverage under section 3(11) of the Congressional Budget Act shall be known as the Medicare Solvency Debt Reduction Reserve.

(b) POINTS OF ORDER TO PROTECT RESERVE.—

(1) Section 301 of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''(j) POINT OF ORDER TO PROTECT MEDICARE SOLVENCY DEBT REDUCTION RESERVE.—

''(1) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget (or amendment, motion, or conference report on the resolution) that would allocate any amount of, or assume a reduction in the Medicare Solvency Debt Reduction Reserve.

''(2) INAPPLICABILITY.—This subsection shall not apply to legislation that appropriates funds from the Catastrophic Prescription Drug Coverage Reserve for catastrophic prescription drug benefits under the Medicare program.''

(2) Section 311(a) of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''(4) ENFORCEMENT OF MEDICARE SOLVENCY RESERVE.—

''(A) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause a decrease in the level of the Medicare Solvency Debt Reduction Reserve.

''(B) INAPPLICABILITY.—This paragraph shall not apply to legislation that appropriates a portion of the Medicare Solvency Debt Reduction Reserve for new amounts for Medicare or catastrophic prescription drug benefits under the Medicare program.''.

(c) SUPER MAJORITY REQUIREMENT.—

(1) Section 904(c)(2) of the Congressional Budget Act of 1974 is amended by inserting ''301(j),'' after ''301(i),''.

(2) Section 904(d)(3) of the Congressional Budget Act of 1974 is amended by inserting ''301(j),'' after ''301(i),''.

SEC. 304. PROTECTION OF MEDICARE SOLVENCY DEBT REDUCTION RESERVE.

(a) REDUCTION OF MEDICARE SOLVENCY TRANSFERS, OR CATASTROPHIC PRESCRIPTION DRUG RESERVE NOT TO BE COUNTED AS PAY-AS-YOU-GO OFFSET.—Any provision of legislation that would reduce, repeal, or reverse the transfers to the Hospital Insurance Trust Fund under section 1817(1) of the Social Security Act or the amount of the Catastrophic Prescription Drug Coverage Reserve under section 3(11) of the Congressional Budget Act, shall not be counted on the pay-as-you-go scorecard and shall not be included in any pay-as-you-go estimates made by the Congressional Budget Office or the Office of Management and Budget under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(b) CONFORMING CHANGE.—Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended, in paragraph (4) of subsection (d), by—

(1) striking ''and'' after subparagraph (A),

(2) striking the period after the subparagraph (B) and inserting ''; and'', and

(3) adding the following:

''(C) provisions that reduce, repeal, or reverse transfers under section 1817(1) of the Social Security Act or the amount of the reserve

under section 3(11) of the Congressional Budget Act.''.

(c) MEDICARE SOLVENCY TRANSFERS AND CATASTROPHIC PRESCRIPTION DRUG RESERVE REDUCE ON-BUDGET SURPLUS.—The transfers under section 1817(1) of the Social Security Act and amounts placed in the reserve under section 3(11) of the Congressional Budget Act, together known as the ''Medicare Solvency Debt Reduction Reserve'', shall be treated for purposes of the President's budget under title 31, United States Code, the Balanced Budget and Emergency Deficit Control Act of 1985, and the Congressional Budget Act of 1974 as reductions to the on-budget surplus (or increases in the on-budget deficit).

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